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# Illinois Medical Journal

OFFICIAL JOURNAL OF THE  
ILLINOIS STATE MEDICAL SOCIETY

APR 28 1981

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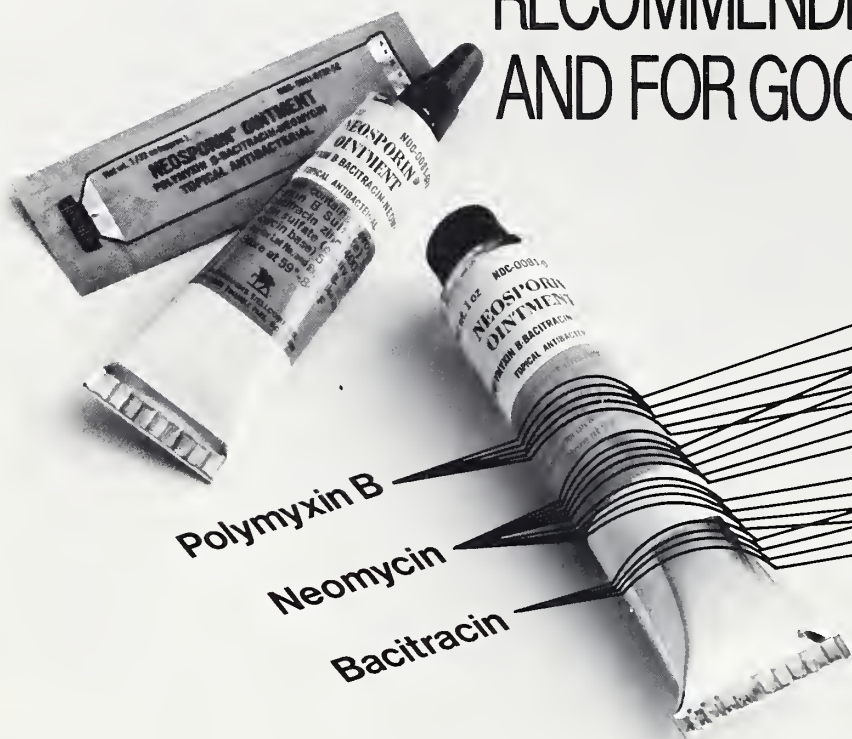
STATE OF MARYLAND  
BALTIMORE

Volume 107, No. 1, January 1980

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# IT'S HIGHLY RECOMMENDED... AND FOR GOOD REASONS



Gram-negative  
Pseudomonas  
Haemophilus  
Klebsiella  
Aerobacter  
Escherichia  
Proteus  
Gram-positive  
Corynebacterium  
Staphylococcus  
Streptococcus  
Pneumococcus

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Neomycin  
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# REPORT

## FOR *Illinois Physicians*

### Experts Discuss NHI at Symposium IV

Despite their widely-varied viewpoints, the speakers at the Chicago-based Blue Cross and Blue Shield Plan's recent symposium on National Health Insurance did agree that the American Health Care system does have some ailments.

Predictably, they offered a wide variety of diagnoses and remedies, ranging from a comprehensive, government-run program to greater reliance on a private competitive approach.

More than 1,000 health care, business and labor executives attended the day-long parley, held at the Regency-Hyatt Chicago Hotel.

Legislatively, the speakers focused on four measures introduced in Congress during 1979: The Carter Administration's bill for mandatory health care cost controls, the Administration's National Health Care Plan; the Health Care for All Americans proposal, introduced by Sen. Edward M. Kennedy, and the catastrophic coverage bill favored by Sen. Russell Long (D., La.).

Leonard Schaeffer, administrator of the Health Care Financing Administration, said Carter's plan would extend protection to the 37 million Americans who have inadequate health insurance, or none at all. He noted that the plan would feature three main elements: Health Care, which would consolidate Medicare and Medicaid into a single administrative structure; the Employer Guarantee, which would require a standard package of benefits for all full-time employees and their families, including protection against costs resulting from major illnesses; and the National Health Care Plan, which would include incentives for development of alternative health care delivery and reimbursement systems, as well as limits

on capital funds "to control excess hospital bed capacity."

Schaeffer estimated the cost of the plan at \$24.5 billion annually, \$17.5 billion of it in new federal costs and \$7 billion in increased employer costs.

A co-sponsor of the Administration's National Health Plan, Sen. Jacob Javits (R., N.Y.), disagrees with some details of the plan, but endorses the concept, "which is essentially Blue Cross and Blue Shield universalized and mutualized."

Javits said enactment of the Long-sponsored catastrophic plan would hurt the chances of enacting the National Health Plan. "The catastrophic plan will reach relatively few people and be very, very expensive. The National Health Plan is far more constructive, especially in terms of preventive health," he concluded.

Another co-sponsor of the Administration bill, Senate Majority Whip Alan Cranston (D., Calif.), predicted that the Senate will eventually reach a consensus on National Health Insurance, recognizing that there must be firm limits on federal spending and direct government program responsibilities.

These limits will dictate a phased-in approach, probably beginning with employer-paid catastrophic coverage through private insurance carriers. "Unfortunately, the concern over additional federal costs will delay the expansion of Medicare and Medicaid benefits," Cranston said.

Sen. Robert Packwood (D. Ore.) said public demand for National Health Insurance has diminished in recent years, thanks largely to improved benefits packages being offered by employers. "The unemployed and the poor are



still falling between the cracks, but is this any justification for imposing a National Health Insurance system on the entire country?" he asked.

Packwood answered that passage of a catastrophic protection measure would remove the excuse for National Health Insurance. "Congress can then address itself to covering the needs of the poor and the unemployed, who have legitimate, justifiable needs, without imposing an unneeded and costly system on the rest of us," he concluded.

Another Congressional critic of pending health care legislation, Rep. David Stockman (R., Mich.), predicted that the Carter and Kennedy bills would create more demand for services and drive costs still higher. He said health care is now viewed as a "spiritual commodity," instead of a product produced by a high technology industry. "There is no real competition, because the only people who can create a competitive market—the consumers—have a passive role in health care purchasing," Stockman asserted.

"The American consumer is a smart shopper. If an employee received a set amount of cash to purchase his own health care protection, he'd select the one that offered the best value for his needs," Stockman concluded.

The pending legislation also drew fire from representatives of the Chicago business community. Robert K. Wilmouth, president of the Chicago Board of Trade, termed the bills "an affront to credulity." He said, "The notion that the high cost of health care can be somehow cured or its delivery made more efficient by having the federal government run it is contrary to the test of logic or the record of experience."

Wilmouth maintained that bringing marketplace techniques into the health care field will control costs and, thus, make it more affordable for all. "The private sector is fully capable of devising alternatives to a government shotgun approach in solving the problems of our uncovered and undercovered citizens."

Bernard J. Lachner, chairman-elect designate of the American Hospital Association and president of Evanston Hospital, countered that there is no health crisis in America. "We are healthier than any other people in the world. What we do have is a health-cost dilemma and an accessibility problem. We have an insatiable public demand for health care. And we need to fill in the gaps."

Rather than support a specific bill, Lachner said, the AHA contends that four principles must form the basis of any National Health Insurance proposal: 1. Health care is the responsibility of the individual, not the government. Health care resources cannot be used to cure social problems; 2. Services must be adaptable to meet the needs of individual communities across the country; 3. The system must recognize limitations on needs and resources, suggesting a phased-in approach; and 4. The organization of services must be flexible and diverse.

Economist Alan Greenspan, former president of the President's Council of Economic Advisers, said a comprehensive National Health Insurance program is "an idea whose time has passed."

Greenspan said that, despite the very strong apparent demands for medical services, the demands for other things are gradually elbowing out the pressures for a comprehensive health plan. "The economic pie isn't getting any bigger, and every day there are more demands for another slice," he explained.

This country, Greenspan said, "is moving toward generic policies of less government expansion, fewer government programs and some constraint on increasing bureaucracy. It is not an accident that Congress has been exceptionally slow to get started this year. It spends very little time on new programs, because the word from the constituencies is somehow getting through."

Consumer advocate Ralph Nader surprised many in the audience by opposing National Health Insurance. He said we could effect sweeping improvements without additional expenditures. He said the individual must accept responsibility for his own health and organize to promote a healthy environment and workplace. "Consumer activism can be a cutting edge in the areas of quality control, cost control, preventive medicine and the expansion of the HMO concept," he contended.

Nader added that large volume buyers of health care, such as General Motors, could exert real bargaining power in preventing inefficiency by providers.

Blue Cross and Blue Shield Executive Vice President Charles Goulet, in opening the program, told the audience "You won't get a rigid blueprint for a National Health Insurance Program." They didn't. He also said "You will get a complete range of views on the topic." They did.





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Cover photo by Ed Stecki

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

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# Clinics for Crippled Children Listed for February

Thirty-two clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 21 general clinics, 10 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Feb. 1 Division Cardiac—U of I at the Medical Center
- Feb. 5 Maryville—Oliver C. Anderson Hospital
- Feb. 5 DuQuoin—Marshall Browning Hospital
- Feb. 5 Wheaton General—Marionjoy General Hospital
- Feb. 5 Park Ridge Cardiac (Morning)—Lutheran General Hospital
- Feb. 5 Park Ridge Ortho. (afternoon)—Lutheran General Hospital
- Feb. 6 Hinsdale—Hinsdale Sanitarium
- Feb. 7 Springfield General—St. John's Hospital
- Feb. 7 Lake County Cardiac—Victory Memorial Hospital
- Feb. 11 Peoria Cardiac—St. Francis Hospital
- Feb. 11 Chicago Heights Cardiac—St. James Hospital
- Feb. 13 Champaign-Urbana—McKinley Hospital
- Feb. 13 Elgin—Sherman Hospital
- Feb. 13 Joliet General—St. Joseph's Hospital
- Feb. 14 Rockford—St. Anthony Hospital
- Feb. 14 Kankakee General—St. Mary's Hospital
- Feb. 14 Aurora Cardiac—Mercy Center for Health Care Svcs.
- Feb. 15 Kankakee Cardiac—St. Mary's Hospital
- Feb. 19 East St. Louis—Community Hospital
- Feb. 19 Maywood General—Loyola Medical Center
- Feb. 20 Springfield Ped-Neuro—St. John's Hospital
- Feb. 20 Chicago Heights General—St. James Hospital
- Feb. 21 Bloomington—Mennonite Hospital
- Feb. 21 Anna—Union County Hospital
- Feb. 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Feb. 22 Evanston General—St. Francis Hospital
- Feb. 25 Peoria Cardiac—St. Francis Hospital
- Feb. 25 Chicago Heights Cardiac—St. James Hospital
- Feb. 26 Peoria General—St. Francis Hospital
- Feb. 26 Belleville—St. Elizabeth's Hospital
- Feb. 26 Rock Island Area General—Moline Public Hospital
- Feb. 27 Aurora General—Mercy Center for Health Care Svcs.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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Please consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



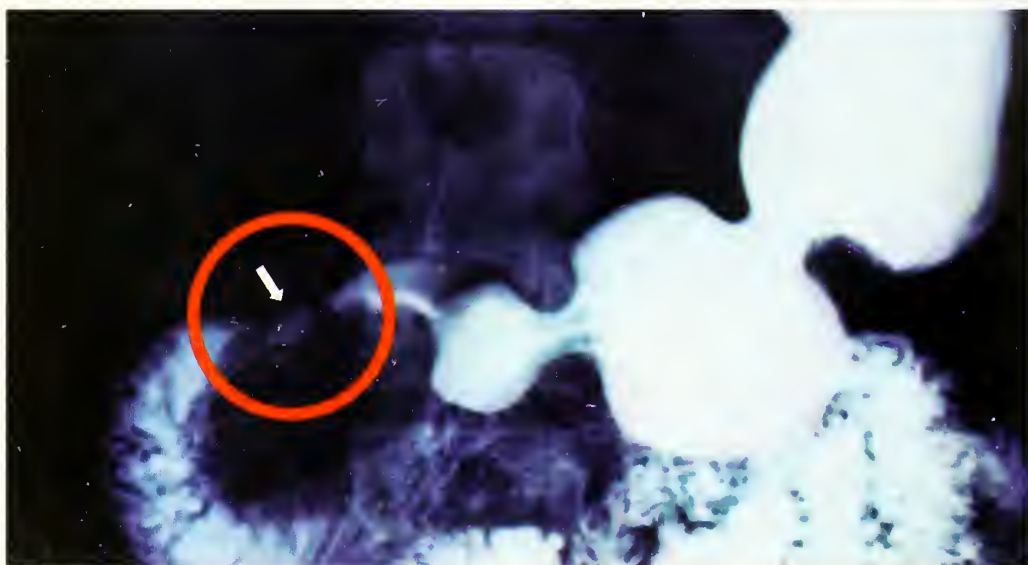
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# The stress-secretion relationship in duodenal ulcer\*



The pituitary gland plays a key role in the neurohormonal response to emotional stress, leading to an increase in gastric secretion.<sup>2</sup>



The duodenal ulcer reflects the erosion of a vulnerable mucosa by acid-pepsin secretion.<sup>2</sup>

The best available evidence<sup>1,2</sup> suggests that chronic anxiety stimulates acid-pepsin secretion. Also, the development of an ulcer crater in predisposed individuals, or the aggravation of ulcer symptoms, is often associated with a stressful event or situation.<sup>1</sup> Thus, anxiety seems to play an important role in the course and prognosis of the disease.<sup>1</sup>

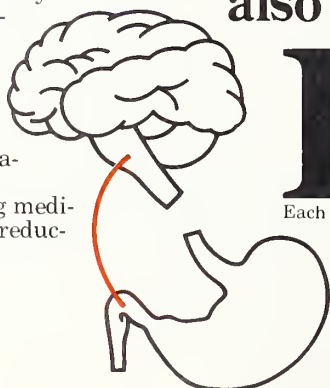
To obtain more comprehensive relief, many duodenal ulcer patients need more than specific, acid-inhibiting medication. They also need reduc-

tion of accompanying anxiety and emotional tension.

**References:** 1. Isenberg J, Richardson CT, Fordtran JS. Pathogenesis of peptic ulcer, chap. 46, in *Gastrointestinal Disease*, ed. 2, edited by Sleisenger

MH, Fordtran JS, Philadelphia, WB. Saunders Company, 1978, vol. 1, pp. 800-801. 2. Sun DCH. Etiology and pathology of peptic ulcer, chap. 27, in *Gastroenterology*, ed. 3, edited by Bockus HL, et al; Philadelphia, WB. Saunders Company, 1974, pp. 579-595.

**More than an antisecretory agent...  
also acts on accompanying anxiety**



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Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**antianxiety/antisecretory/antispasmodic**

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# *Abstracts of Board Actions*

November 9-11, 1979

Decatur

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## **BLOOD BANKING**

ISMS Laboratory Services Committee will establish a statewide coordinating body—including representatives of all blood banks serving Illinois—to set goals and procedures concerning coordinated donor recruitment, inventory control and distribution systems. The action is part of ongoing activities to implement a House of Delegates directive that ISMS assist appropriate agencies in establishing a regionally coordinated state-wide blood banking system.

Funding for the coordinating body—which will not be aligned with any blood bank or system—would be provided through contributions from blood banks. Initially, ISMS—through the Laboratory Services Committee—will provide staff and office services, but will seek developmental funding possibly from the American Blood Commission or other agencies. The Committee will play an advisory role to insure proper operation of the coordinating body and mediate disputes between blood banks. In addition, ISMS will encourage: (1) All blood banks serving Illinois to establish formal relationship with the coordinating body and agree to honor its goals and procedures; and (2) IDPH's Clinical Laboratory and Blood Bank Advisory Board to cooperate with the coordinating body.

## **IMPAC**

The Board concurred in plans of the Illinois Medical Political Action Committee (IMPAC) to sign a conciliation agreement which would resolve Federal Election Commission (FEC) charges of campaign contribution violations and prevent further legal action. The FEC complaint charged that IMPAC and several other state PACs together with the American Medical PAC violated the \$5,000 federal campaign contribution limit. Under terms of the agreement, IMPAC would be held harmless for its previous actions, but henceforth would be bound by the contribution limit. The agreement was formulated with the FEC by attorneys representing IMPAC, AMPAC and the state PACs.

## **MEDICARE REIMBURSEMENT**

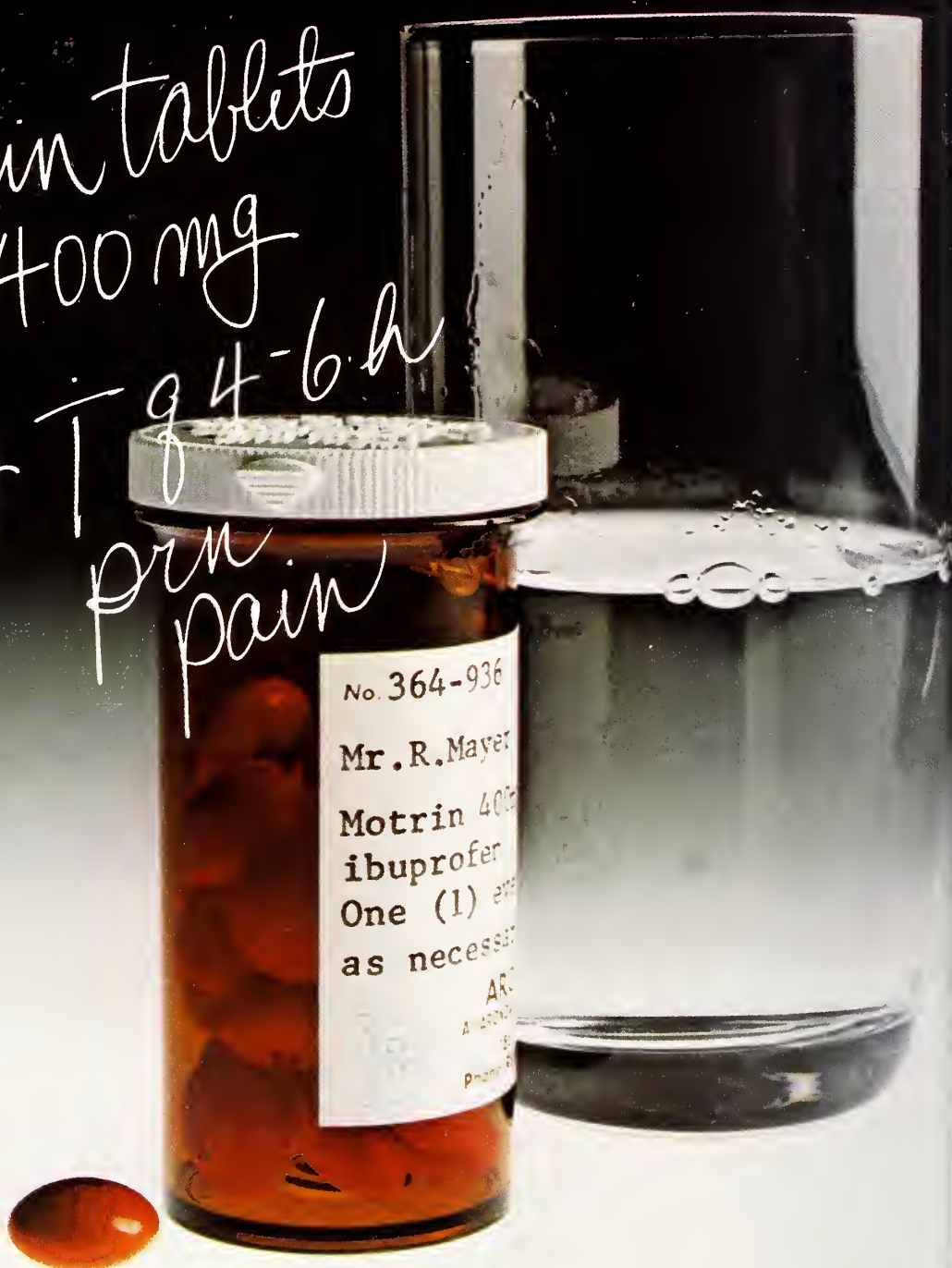
HEW's Midwest Bureau recently acknowledged that the backlog of unpaid Medicare claims had reached approximately 480,000 by the end of October. Included are physician claims as well as those of patients treated by physicians who do not accept Medicare assignment. Representatives of Electronic Data Systems-Federal, the Medicare Part B fiscal intermediary, met with the ISMS Board of Trustees to outline claim processing problems and steps being initiated to reduce the backlog. The Board registered a strong protest over the payment delays. EDS-F—which is subject to penalties if it does not meet processing deadlines—has pledged to do what it can to resolve the problem.

*(Continued on page 53)*



A well-tolerated, nonnarcotic prescription for pain

Motrin tablets  
400 mg  
Sig T q 4-6 h  
prn  
pain





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Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

\*0 = No relief    1 = Partial relief    2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

## Motrin 400mg TABLETS

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- Not a narcotic • Not addictive • Not habit forming
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- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

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# Motrin® (ibuprofen)

## now proved an effective analgesic for mild to moderate pain

### Motrin® Tablets (ibuprofen, Upjohn)

**Indications and Usage:** Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Hypersensitivity reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** Aspirin: used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

### Adverse Reactions

#### *Incidence greater than 1%*

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,\* epigastric pain,\* heartburn,\* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,\* headache, nervousness. **Dermatologic:** Rash\* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

\* Incidence 3% to 9%.

#### *Incidence less than 1 in 100*

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

#### *Causal relationship unknown*

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

**Caution:** Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

MED B-4-S

## Obituaries

**\*\*Davidsohn, Israel**, Chicago, died December 3, 1979, at the age of 84. Dr. Davidsohn was a 1921 graduate from the University of Wien in Austria.

**\*DeHollander, William**, Springfield, died October 17, 1979, at the age of 75. Dr. DeHollander was a 1930 graduate of University of Michigan Medical School.

**\*\*Fahey, Patrick J.**, DesPlaines, died November 16, 1979, at the age of 79. Dr. Fahey was a 1929 graduate of Chicago Medical School. He also was on the staff of Holy Family Hospital.

**\*Froman, Abel**, Chicago, died December 2, 1979, at the age of 74. Dr. Froman was a 1930 graduate of South Carolina Medical School.

**\*Goodman, James E.**, Pleasant Hill, died November 9, 1979, at the age of 59. Dr. Goodman was a 1944 graduate of the University of Illinois Medical School.

**\*Grady, William**, Danville, died December 1, 1979, at the age of 61. Dr. Grady was a 1943 graduate of Jefferson Medical College in Philadelphia.

**\*Kearney, John J.**, Evanston, died November 20, 1979, at the age of 71. Dr. Kearney was a 1936 graduate from the University of Cincinnati Medical School.

**\*\*Litschgi, Joseph J.**, Chicago, died November 24, 1979, at the age of 97. Dr. Litschgi was a 1920 graduate of Chicago Medical School.

**\*Matejka, James J., Jr.**, Chicago, died November 30, 1979, at the age of 63. Dr. Matejka was a 1940 graduate of the Loyola University Stritch School of Medicine.

**\*\*Priest, Walter S.**, Cape Coral, Florida, formerly of Chicago, died December 1, 1979, at the age of 83. Dr. Priest was a 1920 graduate of Washington University in St. Louis, MO.

**\*\*Ricketts, Henry T.**, Chicago, died November 23, 1979, at the age of 78. Dr. Ricketts was a 1929 graduate of Harvard. He also was a past president of the American Diabetes Association and a founder and president of the Chicago Diabetes Association.

**\*Sarmiento, Roberto R.**, Markham, died November 19, 1979, at the age of 54. Dr. Sarmiento was a 1949 graduate of the University of Havana in Cuba.

**\*Schlan, Louis**, Chicago, died November 10, 1979, at the age of 71. Dr. Schlan was a 1937 graduate of the University of Illinois Medical School.

**\*Stelzner, Burkhardt H.**, Oak Park, died October 7, 1979, at the age of 54. Dr. Stelzner was a 1951 graduate of the University of Marburg/Lahn, Hessen, Germany.

**\*Thorner, Melvin W.**, Lake Bluff, died November 7, 1979, at the age of 72. Dr. Thorner was a 1932 graduate of Jefferson University.

**\*Thrasher, Irving Dana**, Chicago, died November 22, 1979, at the age of 74. Dr. Thrasher was a 1931 graduate of Johns Hopkins University School of Medicine. Dr. Thrasher served on the staff of Henrotin Hospital for 45 years.

\* Indicates ISMS member

\*\* Indicates ISMS member of the fifty year club

# The Viewbox

Contributing Editor Leon Love, M.D., chairman, Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was submitted by Terrence Demos, M.D. Asst. Professor of Radiology, Loyola Univ. Med. Center, Maywood, Illinois*

*This 33-year-old man has a sore throat which has become increasingly worse in two days. It is very difficult for him to swallow and he now has slight difficulty breathing. (White dots below hyoid bone are artifacts.)*



**Figure 1**

## ***What's your diagnosis?***

1. Retropharyngeal abscess
2. Epiglottitis
3. Angioneurotic edema
4. Foreign Body
5. Subglottic edema—croup

*(Continued on page 16)*





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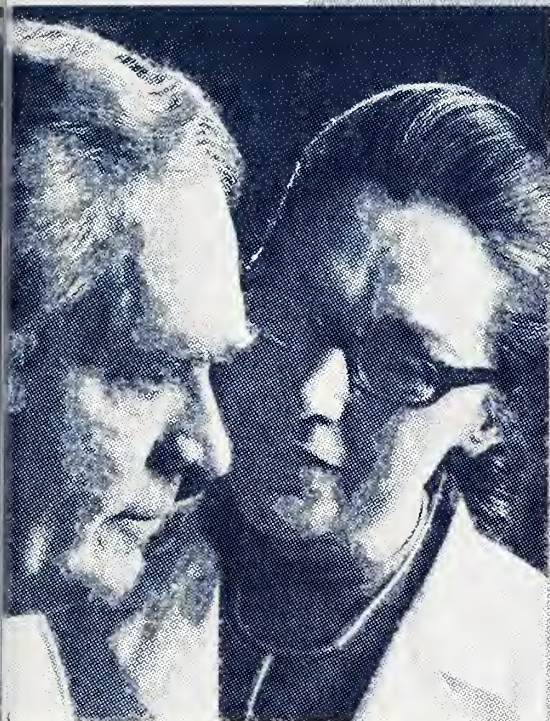
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The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

**Librium<sup>®</sup>**  
*chlordiazepoxide HCl/Roche*

LIBRIUM<sup>®</sup> 5mg ROCHE   LIBRIUM<sup>®</sup> 10mg ROCHE   LIBRIUM<sup>®</sup> 25mg ROCHE   LIBRIUM<sup>®</sup> 25mg ROCHE   LIBRIUM<sup>®</sup> 25mg ROCHE  
5mg, 10mg, 25mg capsules

***synonymous  
with relief  
of anxiety***

- ☐ An unsurpassed safety record
- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.



# Librium® 5mg, 10mg, 25mg capsules

## chlordiazepoxide HCl/Roche

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Products Inc.  
Manati, Puerto Rico 00701

## Viewbox

(Continued from page 11)

### DIAGNOSIS: Acute Adult Epiglottitis

All choices listed are causes of acute upper airway obstruction. Difficult breathing and stridor characterize acute airway obstruction which is more common in children due to the small caliber of their airways.<sup>1</sup> Acute epiglottitis, especially, is considered a problem of infants and children. Not so. In one series of 47 cases of acute epiglottitis, 10 patients were adults. Proper diagnosis had been made initially in only four of these 10.<sup>2</sup>

The diagnosis is easily overlooked in adults. A patient treated early with antibiotics may improve and be considered to have pharyngitis. If treatment is delayed, rapid progression of supraglottic swelling can be lethal. (There is evidence that George Washington died of acute epiglottitis.)<sup>3</sup>

This diagnosis should be considered in an adult with a severe sore throat and dysphagia or difficult breathing. Difficulty with secretions and stridor are also frequent.<sup>4</sup> Intubation or tracheostomy may be necessary. IV antibiotics and steroids often provide relief of symptoms without tracheostomy, however.<sup>5</sup> Examination of the pharynx may be difficult and dangerous. If the diagnosis is in doubt and the clinical condition of the patient allows it, a lateral X-ray of the neck will safely establish the diagnosis. The supraglottic structures, especially the epiglottis and aryepiglottic folds (Fig. 1), are enlarged. The hypopharynx may be distended.

Most patients have bacterial infections. Hemophilus, Streptococcus, and Staphylococcus species are most common and Hemophilus is often associated with severe infections.

The patient presented here responded promptly to IV ampicillin and steroids. Tracheostomy was not required.

### References

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2. Schabel, S.I., Katzberg, R.W., Burgener, F.A.: "Acute Inflammation of Epiglottis and Supraglottic Structures in Adults." *Radiology* 122:601, 1977.
3. Scheidemandel, H.M.: Did George Washington Die of Quinsy? *Arch Otolaryngol* 102:519, 1976.
4. Case Records of the Massachusetts General Hospital: *N. Engl. J. Med.* 297:878, 1977.
5. Hawkins, D.B., Miller, A.H., Sachs, G.B., et al., "Acute Epiglottitis in Adults," *Laryngoscope* 83: 1211, 1973.



# Student Business Session in Action

## *SBS Fall Educational Seminar*

The Florentine Room of the Pick-Congress Hotel in Chicago was the site for the most recent SBS educational seminar, entitled "Government in Health Care: How Much is Enough?" The strengths of the program lay in the diversity of its speakers. Representatives from community hospitals, group insurers, the university community and the U.S. Congress were called upon to air their views.

Dr. Quentin Young, chairman of the department of medicine at Cook County Hospital, spoke on "The Case for a National Health Service," to open the program. Noting that about one-half of hypertension in the United States goes undetected, Dr. Young charged that today's health care system suffers from overuse of high technology resulting in runaway costs and a failure to meet the basic health needs of the nation. He suggests that a National Health Service is an advantageous means of health care delivery because of its orientation toward cost containment, its emphasis on early prevention through detection and its increased patient involvement in decision making.

"The Role of Volunteerism," was addressed by Henry J. Bachofer of the American Hospital Association Office of Policy Studies. Mr. Bachofer emphasized the vital role of volunteerism in our current health care system, where absolute government control and the forces of the free market do not apply. Volunteerism was cited as a vital component in application of health care to the diverse environment of the United States as well as a mode of flexible response to rapid developments in the health field. Ultimately, we will be forced to define roles for both the public and private sectors, Mr. Bachofer suggested. Government must set social goals with individual initiative matching personal desires to achieve broad ends.

Blue Cross/Blue Shield Association was represented by Don Sacco, Senior Director of Health Care Management, Policy and Planning. Mr. Sacco, in his presentation "Cost Conscious Decision Making" cited the varied activities of his association in review of health care offerings in

this country with the caveat that planning can only be done on a regional basis due to the diversity of need. He concluded that we require an intelligent combination of regulation and competition in which the M.D. participates at the staff level in hospitals, in community level planning efforts and through organized medicine in the provision of cost effective medical care.

Richard Foster, Ph.D., Associate Director, University of Chicago Center for Health Administration Studies, spoke to the effects of cost control on the M.D./patient relationship in his presentation "The Health Care Controversy: Here to Stay." Citing pressures from Medicare and Medicaid at the national and state levels along with union bargaining in contract settlements, Mr. Foster suggests the time is coming when health care at the doctor and patient level will be changed by economic concerns. The alternatives we face are heavy government regulation, a competitive system of HMOs and insurers or a shared cost program involving doctors and patients.

"Viability of the Private Sector in Health Care Delivery" was addressed by Representative Daniel B. Crane of Illinois. Mr. Crane, stating that health care was a privilege and not a right, pointed an accusing finger at government involvement as the true crisis in health care. Noting that government lacks both efficiency and motivation toward self-control, Representative Crane decried today's inundation with federal controls and recommended individual initiative framed in a Judeo-Christian system of morals.

This represents one in a series of seminars produced by the ISMS-SBS. It was exceptionally well attended by medical students, physicians and the general public. Brad Epstein, vice-chairperson and David Whitney, delegate, coordinated the seminar. SBS is presently seeking suggestions for future seminars and the officers of SBS would be pleased to discuss any aspects of our most recent effort.

David J. Dries  
Secretary/Editor

*This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Student Business Session.*



# The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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**Contraindications:** Hypersensitivity to the drug.

**Precautions:** Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

**Adverse Reactions:** Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

**Dosage and Administration:** 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Before prescribing, see package insert for full product information.

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# Editorial

## *Catching The Eye*

Most of us read or investigate items which "catch our eye" or are appealing to our senses. The more eye appeal an item may have, the greater the chance that we, as consumers or product users, will be drawn to the particular attention stopper. This concept of attention-getting plays a role in our lives every day of the year—the child screams, the parent spansks, the editor editorializes or presents interesting, intriguing articles. The editorial board and publications committee must be cognizant of the needs and the desires of its reading community. They must present these requirements in a palatable and enjoyable fashion to constituents.

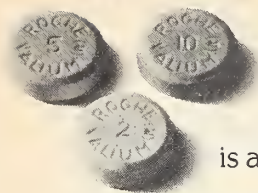
Our constituency is the membership of the Illinois State Medical Society—all physicians or prospective physicians. These individuals—men and women—represent one of the most knowledgeable and talented group of people in the United States and in Illinois. They are dedicated to their profession and to their hobbies—whatever those may be. Many of our membership are very capable sculptors, photographers, artists, writers, painters, etc. We are aware of them locally but not on the state level. Individual physician talents are quite commonly presented in the non-medical media including newspapers, magazines, art exhibits and displays.

Recognizing the need of the editorial board to present a journal to its membership which is both catching and informative, and yet fits into the budget limitations of the society, we would like to ask our membership to submit their ideas and talents to the editor for presentation on the *Journal* cover. Yes! We would like to receive 5" x 7" (black and white) prints and illustrations which you feel would be appropriately considered as the cover page of the *Illinois Medical Journal*. Everyone fancies himself as an artist in one way or another. Let's submit that talent to the Board for presentation and recognition. Please forward your item to the Board for their review. ◀

Raymond A. Dieter, Jr., M.D.  
Member, Editorial Board  
*Illinois Medical Journal*



# A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

**Valium<sup>®</sup> <sup>IV</sup>**  
**diazepam/Roche**  
2-mg, 5-mg, 10-mg scored tablets  
**a prudent choice in psychic  
tension and anxiety**

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

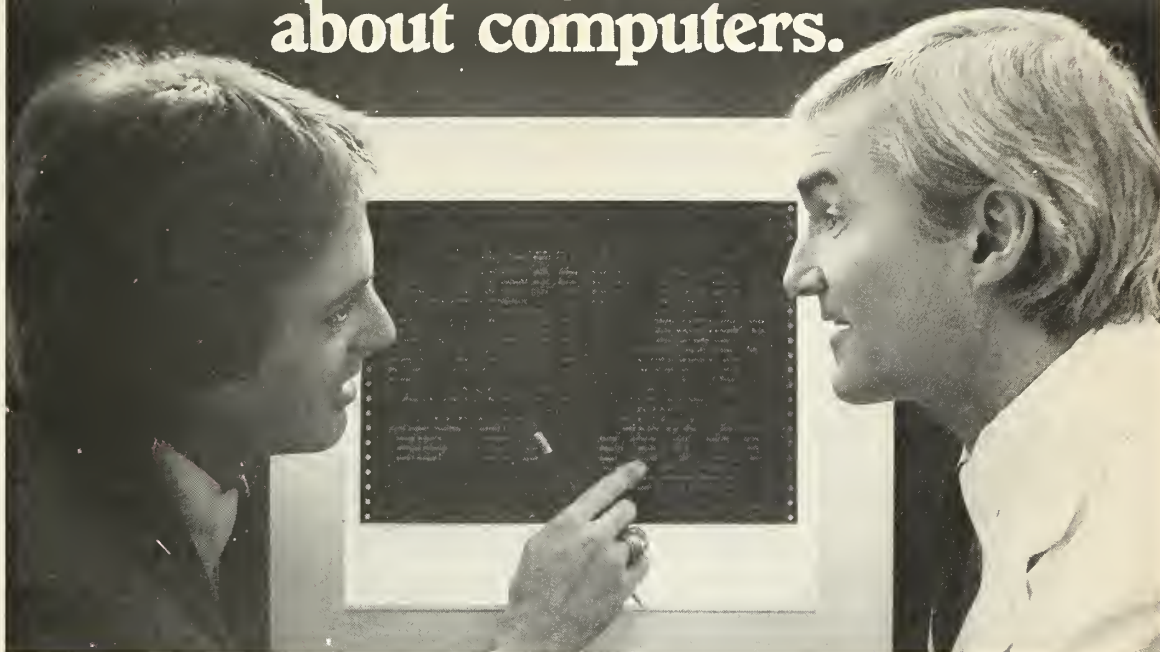
**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium<sup>®</sup> (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose<sup>®</sup> packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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# Illinois Housestaff News

## Residents Active At ISMS Interim Meeting

BY LINDA HUGHEY HOLT, M.D./CHICAGO

ISMS delegate Bill Golden and alternate David Olive attended the 1979 ISMS meeting at Decatur. They drafted and entered several resolutions from the ISMS-RPS, continuing the tradition of active resident participation in statewide ISMS meetings.

One bill coming out of the RPS called for establishment of an emergency loan fund for residents. This fund would make short-term loans available to residents to meet emergency needs. It was noted during preliminary discussion among ISMS-RPS Governing Council members that AMA loans are available to residents but that processing of these loans may take as long as a month. In a situation such as the recent paycheck delay at Cook County Hospital, short-term but immediately available loans would be of use to many residents in helping to ride out the crisis.

A second proposal by the ISMS-RPS involved support for the *concept* of county hospitals. ISMS support for this concept had already been expressed by ISMS president, Dr. Seward, in an Oct. 15 press release. "State, county, and city government all have a responsibility to County Hospital and the patients it serves," he noted. "The (Cook County) Hospital provides a substantial volume of care to the indigent." Although most Illinois hospitals provide some services to the poor, they are not equipped to handle the burden of extra patients should County be forced to close. Dr. Seward did not offer any pat solutions, but commented that "our concern is the continuation of medical services to the area's poor, not the intricacies of government finance."

Other proposals offered by the resident group to the Interim Meeting included a proposal for increased funding and a suggestion that the requirement of attending an orientation meeting be dropped as a requirement for local medical society membership. Residents are usually working under rigid schedules and are unable to arrange attendance at meetings occurring far from their hospitals.

Results of the above proposals will be covered in a future column.

### University Of Chicago Student Suspended For "Medical Ethics" Violation

In the Spring of 1979, a second year student from the University of Chicago's Pritzker School of Medicine was suspended for a "serious breach

of medical ethics." Was his crime cheating on a test, stealing from the hospital, or lying about patient care matters? No. His crime, it turns out, was that he wrote an article for the *Chicago Reader* about his experiences as a triage officer in the hospital's emergency room. More specifically, he failed to clear the presence of a photographer in the emergency room through the hospital's public relations department, although he did inform the ER staff and the photographer obtained consent of all patients used in pictures.

Fellow students have been petitioning for a reconsideration of the suspension on the grounds that the penalty is out of proportion to a minor infringement of hospital procedures. One student commented, "The action was at most foolish and a little arrogant; if those qualities constitute a 'breach of medical ethics' then 80% of our Attendings are guilty of the same!" The student in question was considering legal action for a repeal of the suspension. (In December the suspension was lifted.)

The take-home lesson for students and residents alike is that medical personnel-in-training are extremely vulnerable to criticism from their superiors. In several situations on file in the AMA Department of Housestaff Affairs legal department, residents have found themselves dismissed from their programs due to what the residents feel are personality conflicts. Even when due process is guaranteed the residents in their contracts, few residents have chosen to make use of it. When residents have chosen to fight an arbitrary dismissal, their superiors quite often have challenged the residents' professional competence or ethics. No resident wants to have on his file a challenge of his moral or professional competence. Hence most residents facing a faculty member who is seriously trying to terminate them from the program will leave voluntarily rather than face a fight for due process. Any resident caught in the unfortunate position of having a faculty member trying to dismiss him from the program should be very cautious, as he has very little legal protection and is very vulnerable during his training to assaults on his competence or moral character. For residents caught in this unfortunate position, legal advice may be obtained from the AMA Department of Housestaff Affairs. Further, the ISMS-RPS can put the residents in contact with some members who have experience with resident legal problems. ◀

\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.



# I M J

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## Preventable Neonatal Respiratory Distress Syndrome (RDS) In North Central Illinois

BY WILLIAM F. POWERS, M.D., M.P.H./PEORIA

*One hundred consecutive cases of RDS (respiratory distress syndrome) admitted to the Newborn Intensive Care Unit serving North Central Illinois were reviewed to determine the incidence of "iatrogenic RDS." Twenty cases resulted from direct physician intervention (elective induction or elective repeat cesarean section). Another eight cases resulted from pregnancies in which the onset of labor was spontaneous, but in which an attempt at stopping labor was probably indicated. Clinical situations leading to "iatrogenic RDS" are discussed, so that they can be identified and hence avoided.*

Advances in prevention and treatment of neonatal respiratory distress syndrome (RDS) have undoubtedly contributed to the decline in the United States' perinatal mortality rate that has occurred in the last decade.<sup>1</sup> These advances include amniotic fluid analysis for pulmonary maturity, the emergence of newborn intensive care

units, and the development of continuous alveolar distending pressure. However, RDS still remains the major cause of perinatal morbidity and mortality in the United States.<sup>2</sup> Several perinatal centers report that a substantial portion of the remaining cases of RDS seen in their nurseries results either from nonuse or misuse of some of these same advances in perinatal care.<sup>3-6</sup> For instance, in the Yale-New Haven Hospital one-third of the RDS seen is "iatrogenic" in origin.<sup>4</sup> This is particularly ironic, for Dr. Louis Gluck, the discoverer of the value of the Lecithin/Sphingomyelin (L/S) ratio, spent a large portion of his medical career at this same center.

Since regional perinatal centers are charged with monitoring perinatal care practices in their

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Figure 1.

Shaded area represents the North Central Illinois Perinatal Region.

regions, and providing appropriate educational remedies for emerging problems,<sup>7</sup> a review of recent cases of RDS treated in the Newborn Intensive Care Unit (NICU) at St. Francis Hospital-Medical Center in Peoria, Illinois, was undertaken. RDS is still a major problem in this perinatal region, for of the approximately 700 infants admitted annually to this unit, about 200 have RDS, and about 30 die of this disease or its complications. The frequency of so-called "iatrogenic RDS" in this region was ascertained so that health care providers might be made aware of the scope of the problem, so that situations leading to "iatrogenesis" might be anticipated and hence avoided, and continuing medical educational activities might be rationally planned. A summary of this audit follows.

## Materials and Methods

One hundred consecutive cases of RDS were analyzed. These infants were born over a six month period, and their birth places were scattered throughout the perinatal region. (Figure 1) For purposes of this review, respiratory distress syndrome (RDS), or clinical hyaline membrane disease, was diagnosed only when three specific criteria were met. First, the child had to have had a chest X-ray with the typical radiographic appearance of RDS as reported by the radiologist, or a specific comment by the neonatologist that the child had RDS despite the X-ray report. Second, the child had to have a supplemental oxygen requirement lasting for at least 48 hours, or a supplemental oxygen requirement until the moment of death, if death occurred in less than 48 hours. Finally, other obvious causes of respiratory distress such as pneumonia, sepsis, transient tachypnea of the newborn, meconium aspiration, etc., were not present. The data presented were gathered from the mothers' and infants' hospital charts, from office and clinic prenatal records, and from the hospital business office.

Cases of RDS were classified as (1) unpreventable, (2) due to physician commission (an elective action was taken when none was indicated), or (3) due to physician omission (an action was not taken when one might have been indicated). Examples of cases of RDS due to physician commission were those resulting from elective repeat cesarean section, or elective induction without appropriate assessment of fetal maturity. Cases of RDS classified as due to physician omission were all cases where labor onset was spontaneous, but the patient might have been a candidate for stopping labor (prematurity, intact membranes, less than or equal to 3cm dilatation, "weak" contractions). Cases of RDS which did not clearly fit into either of the first two categories were classed as unpreventable. This category included all cases of RDS following premature rupture of membranes, although some might argue that delivery could occasionally be safely delayed in this circumstance. In all instances, the benefit of doubt was given to the decision to deliver.

Standard statistical methods were applied.<sup>8</sup>

## Results

Of 100 RDS cases reviewed for this audit, 20 were considered to be due to physician commis-



sion, and another eight due to physician omission. These are summarized in Tables 1 and 2.

Of the 20 "commission" cases, 15 followed elective repeat cesarean section. In the first 12 instances, no attempt was made to objectively document fetal maturity. In case 13, fetal biparietal diameter was measured sonographically, but this measurement was made at a time in pregnancy when sonography is of limited value for assessing gestational age (38 weeks). In case 14, an L/S ratio was obtained, but the laboratory and the delivering physician may have failed to interpret the data correctly; the infant developed RDS after delivery. Infant 15, an infant of a diabetic mother (IDM), was delivered after a "mature" L/S ratio, even though the fetus was premature and showed no evidence of intrauterine compromise.

In cases 16 and 17, labor was induced electively, and in cases 18 through 20, weak and probably ineffectual labor patterns were enhanced. In none of these last five cases was either an L/S ratio or sonogram performed. Case 18, the only infant of the 28 reported in this series who died, probably died from asphyxia rather than from RDS. Despite reportedly good Apgar scores, this infant had seizures which began in the first 24 hours of life. Post mortem examination of the brain revealed severe anoxic changes.

The obstetrical antenatal estimate of gestational age was 2.35 weeks greater than the pediatric estimate,<sup>9</sup> a highly significant difference (paired  $t = 3.13$ ,  $p < 0.01$ ). The mean birth weight of these twenty babies ( $2596 \pm 553$  grams, mean  $\pm$  S.D.) was significantly greater than the birth weight of the usual baby admitted to our nursery with RDS ( $1901 \pm 715$  grams) ( $t = 4.16$ ,  $p < 0.01$ ). Likewise, the gestational age of the twenty babies delivered following physician intervention was greater than the gestational age of the general RDS population ( $36.45 \pm 1.54$  weeks versus  $32.97 \pm 3.70$  weeks) ( $t = 4.03$ ,  $p < 0.01$ ).

These 20 babies had fairly severe RDS, for 16 of them needed either continuous distending pressure or mechanical ventilation for a total of 79 days. They spent 136 days in supplemental oxygen and 319 days in the hospital.

Cases 21 through 28 are presented as cases of RDS resulting from physician "omission." Because of the clinical status of these mothers at the time they presented to the hospital (pre-term, membranes intact, less than 4cm cervical dilatation, and an early labor contraction pattern), some suggest that an attempt should be made to inhibit these labors<sup>10</sup> with such medications as

alcohol, isoxsuprine, or magnesium sulfate. Labor inhibition could certainly have been considered in cases 21 through 24, although this does not imply that labor could have definitely been stopped in any or all of these cases. Cases 25 through 28, though premature, are harder to classify. While strictly speaking they fulfill the criteria for consideration of tocolytic agents, many physicians would probably not attempt to inhibit labor this late in pregnancy. They are included for the sake of completeness.

None of these eight "omission" babies died. Their morbidity is reflected by their need for respiratory assistance and supplemental oxygen, as well as by the duration and costs of their hospitalizations (Table 2). Greatest morbidity was experienced by infants 21 through 24, the same four infants in whom tocolysis seemed most indicated.

## Discussion

Several limitations of this study are apparent. Any categorization of RDS as unpreventable, due to commission, or due to omission, is somewhat arbitrary. Another reviewer, in considering these same 100 cases, might conclude that the incidence of "iatrogenesis" was higher or lower than is described in this report. For instance, some might argue that the inclusion of cases 25 through 28 artificially raises the incidence of "iatrogenesis." On the other hand, no case of RDS following premature rupture of the fetal membranes was considered as "iatrogenic" even though the rupture might have occurred early in the third trimester, and was followed by oxytocin induction in the absence of signs of maternal systemic illness. Some reviewers would object to automatically excluding these cases from the iatrogenic category, for some modern protocols call for watchful waiting in this situation.<sup>11</sup> These reviewers would suggest that the reported incidence of "iatrogenesis" is artificially low.

Another limitation of this study is its retrospective nature. Some vital information may not have been recorded or transmitted, *i.e.*, an L/S ratio might have been performed, but not recorded. If this were the case, however, it would represent a serious problem in chart maintenance.

A third limitation is that only cases of RDS referred to this NICU are included. Other babies with RDS who were born in this region but died before they could be referred, whose disease was so mild that they were not referred, or who were born in this region but sent to other NICU's would, of course, not be included in this audit.

**TABLE 1**  
**RDS/HMD in Infants Delivered Following Active Physician Intervention**

Case	Gest. Age Weeks		Birth Weight Grams	Mode of Delivery			Days on Vent. CPAP	Days in Supple- mental Oxygen	Hospital Days
	OB	PEDS							
1	40	35	2395	Elective	Repeat	Section	4	7	17
2	38	37	2523	"	"	"	2	4	11
3	39	40	3374	"	"	"	3	7	27
4	37	37	2169	"	"	"	—	3	11
5	38	36	2665	"	"	"	4	9	20
6	40	37	2892	"	"	"	4	5	10
7	40	36	2268	"	"	"	7	14	23
8	40	34	1650	"	"	"	24	25	35
9	40	36	2608	"	"	"	—	2	6
10	38	37	3544	"	"	"	2	4	8
11	40	39	2892	"	"	"	—	3	6
12	40	36	2460	"	"	"	4	5	11
13	38	38	2381	"	"	"	2	5	10
14	40	36	2480	"	"	"	5	8	19
15	34	35	3643	"	"	"	4	5	26
16	38	38	3218	Elective Induction			6	13	26
17	38	37	2381	Elective Induction			—	3	8
18	37	36	2465	Amniotomy Following Ineffectual Contractions			2	2	2
19	42	34	1888	Pitocin Augmentation of Ineffectual Contractions			2	6	25
20	39	35	2098	"			4	6	18
<b>TOTALS</b>							79	136	319
<b>MEANS</b>	38.8	36.45	2596				4.94	6.8	16
<b>S.D.</b>	± 1.70	± 1.54	± 534						

**TABLE 2**  
**RDS/HMD Infants Delivered Following Spontaneous Onset of Premature Labor When Attempt at Labor Inhibition May Have Been Considered**

Gest. Age Weeks		Description of Contractions At Time of Hospital Admission			Station	First Exam			Interval Between Hospital Admission And Delivery (Hours)	Birth Weight (gms)	Days on Ventilator or CPAP	Days on Supplemental Oxygen	Days in NICU
29	31	15-20	9	Mild	—2	3	—	Intact	8½	1318	—	3	41
27	28	Short	5-7	—	—1	3	Thin	Intact	12	856	9	38	55
32	35	20-30	5	—	—	1-2	Thin	Intact	11½	2197	5	6	12
28	28	—	3-8	—	Floating	3	—	Intact	8	964	1	4	84
35	36	—	—	Tightness	—3	0	—	Intact	18	1920	—	2	4
36	35	—	10	Mild	—1	3	75	Intact	13	2900	2	5	9
35	32	30	5	Moderate	0	1	80	Intact	7½	1729	15	22	34
35	35	—	7	Irregular	—1	2	80-90	Intact	5	2070	5	7	17

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Hence these data reflect RDS as seen in this unit, rather than in this region, although in all likelihood there is a close correlation between the two.

Despite these limitations, these data illustrate that fully 20% of the RDS seen in this nursery results from direct physician intervention. Had the delivering physician known that RDS was to result from his actions, he may not have intervened. Yet in nearly all cases, little was done to objectively document pulmonary maturity or gestational age. Eight additional cases of RDS (Table 2) possibly resulted from physician inaction when at least some feel that action, *i.e.*, attempting to inhibit labor, might have been indicated.

Several points can be learned from this review. First, *there is a very real hazard associated with elective repeat cesarean section*. Fifteen cases of RDS in our series of one hundred followed elective repeat cesarean section. Recent data from two large Chicago hospitals indicate that 12% of all elective cesarean sections resulted in RDS.<sup>6</sup> The risks of elective cesarean section need to be considered very seriously by delivering physicians.

Secondly, *clinical estimates of gestational age made antenatally often are inaccurate* (Table 1). Indeed one error of six weeks was made! Thus, it is hazardous to schedule elective delivery, either by cesarean section or induction only on the basis of maternal dates, for these dates are so often misleading. One way to decrease the hazard of elective repeat cesarean section would be to emphasize to mothers while they are still in the hospital after their first cesarean section the risks associated with their subsequent pregnancies, and the need for accurate observations concerning menstrual flow, early examination in subsequent pregnancies, early confirmation of pregnancy, and accurate recording of quickening.

Even with optimal antenatal clinical assessment of gestational age, however, some estimates of gestational length will still be uncertain. Hence, confirmatory tests are often essential.

The third point to be learned from our data is that these *confirmatory fetal tests can frequently be misapplied or misused*. For instance, a fetal radiograph for distal femoral epiphyses was performed in case 19, and this information probably influenced the decision to augment labor, even though fetal radiographs are notoriously unreliable,<sup>12</sup> and no longer recommended for assessing duration of gestation. Sonographic measurement of biparietal diameter has been shown to be a reliable method of assessing gestation. However,

this technique must be used in the proper manner. Measurement of biparietal diameter at 38 weeks, as was done in case 13, is not reliable, for the accuracy at this stage of gestation is diminished. To obtain valuable gestational age information from sonography, two sonograms must be done at least four weeks apart, and these must be performed from about 20 to 30 weeks' gestation. As an alternative, fetal crown-rump length can be measured between the eighth and fourteenth week.<sup>13</sup> In either event, however, sonography must be performed early in pregnancy, and it is of limited value in assessing gestational age in the last few weeks of pregnancy. If sonography is to be done, it is best when done early.

The fourth point to be noted is that *just because a fetus is large, or of advanced gestational age, is no guarantee that pulmonary maturity has been attained*. The infants who developed respiratory distress following physician intervention were much larger and of greater gestational age than the average baby with RDS. Others have noted this same pattern.<sup>3,5</sup> Pulmonary maturity can be assessed antenatally only by analysis of the amniotic fluid. Because of the uncertain status of pulmonary maturity, some have prohibited elective intervention in a pregnancy unless fetal pulmonary maturity has been documented.<sup>14</sup> Even those who disagree with this dogmatic approach of routine L/S ratios before every elective intervention still perform L/S ratios quite liberally whenever there is the slightest doubt about maturity.<sup>15</sup>

Finally, *several comments on the L/S ratio are in order*. First, *it is well known that in pregnancies complicated by maternal diabetes, RDS can develop even after "mature" L/S ratios have been obtained*.<sup>16,17</sup> This occurred in case 15. Hence it is currently recommended that IDM's not be delivered before 37 weeks' gestation despite mature L/S ratios unless estriol determination or oxytocin challenge tests show evidence of fetal compromise.<sup>18</sup> Infant 15 was delivered by elective repeat cesarean section at 34-35 weeks' gestation after a "mature" L/S ratio, even though there was no evidence of fetal compromise. As an alternative, certain research centers are currently performing a more sophisticated test on amniotic fluid to test its phosphatidyl glycerol content as a way to predict pulmonary maturity in diabetic pregnancies.<sup>16</sup>

Also, the L/S ratio is not just another test for the laboratory to report. It is a very difficult test to perform, and sometimes very difficult to interpret. In different centers, different numbers

represent pulmonary maturity, depending on the biochemical techniques used. In case 14, an L/S ratio of 2.2, classified as "early mature" by the laboratory, was obtained prior to cesarean section. The delivering physician understandably interpreted this as representing pulmonary maturity, whereas the pathologist felt that this ratio was still consistent with a significant risk of RDS.

Since the only way to ascertain the value of an L/S ratio performed in a particular laboratory is for the laboratory to trace the clinical outcome of the patients, the laboratory and the clinician are obliged to communicate freely. However, this vital communication does not occur as frequently as one would hope. In this perinatal center, an attempt is made to get follow up information on all infants who have an L/S ratio performed during pregnancy. Results are periodically tabulated so as to be able to predict the chances of a baby developing RDS if he is delivered within two days of obtaining a given L/S ratio.

## Summary

Fully 20% of the RDS seen in our NICU occurs in infants delivered after physician intervention. Other cases occurred after no attempt was made to stop labor. The morbidity encountered by these infants is substantial. The repeat elective cesarean section is a particularly hazardous clinical situation. Accurate assessment of gestational age by thorough history and physical examination would help to alleviate part of this problem. Sonograms done at the appropriate times early in pregnancy can yield valuable information. Fetal X-rays for appearance of epiphyses are of no value.

Analysis of amniotic fluid is the only certain way to predict pulmonary maturity, but correct interpretation of L/S ratios or bubble tests demand careful scrutiny of the clinical situation and the laboratory technique. Finally, communication between the laboratory and the delivering physician is essential to maintain the accuracy of the L/S ratio. If these measures are strictly adhered to incidence of "iatrogenic RDS" will decline. ◀

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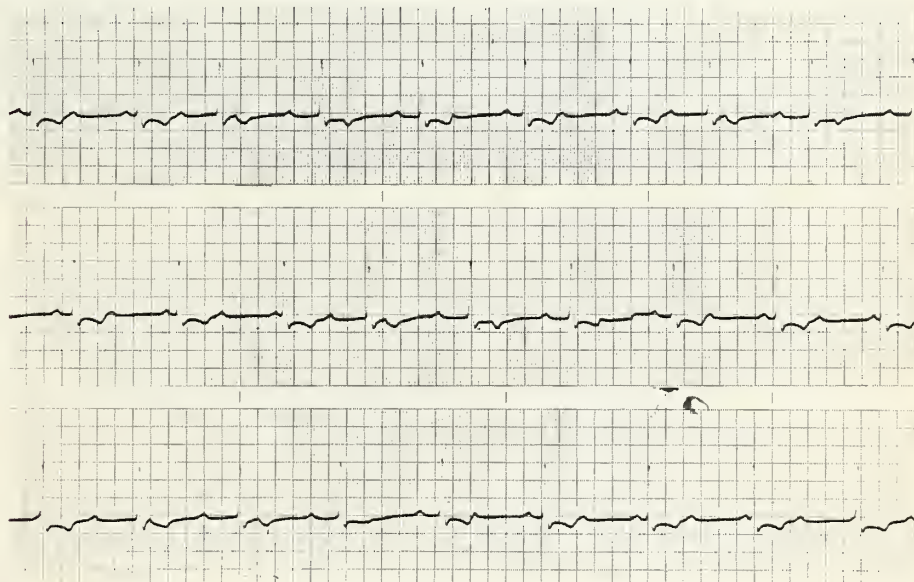
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# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a sixty-one year old man who initially presented with complaints of severe exertional angina and near syncope. The physical examination was compatible with severe aortic valvular stenosis. A cardiac catheterization confirmed the presence of severe, calcific, aortic valvular stenosis and demonstrated normal coronary arteries. The patient underwent open heart surgery and a prosthetic aortic valve replacement was performed. He had an uneventful postoperative course until the eighth postoperative day when he had a bout of shaking chills and a temperature of 39.0° C. Blood cultures were negative but a urine culture was positive and appropriate antibiotics were administered. He improved and did well for a month. At that time, he again had shaking chills and spiked a temperature. He was readmitted to the hospital. A new diastolic murmur suggested that aortic regurgitation was present. On the second hospital day, the ECG rhythm strip was recorded.



## Questions:

### 1. The ECG rhythm strip show(s):

- A. Type I second degree atrioventricular (AV) block (Wenckebach).
- B. Type II second degree AV block (Mobitz).
- C. Severe or high grade AV block, with occasional sinus capture beats.
- D. Incomplete AV dissociation.
- E. Premature atrial beats.

B. The mortality with infected prosthetic valve endocarditis is as high as 75 to 80%.

C. *Staphylococcus aureus* or *epidermidis* are most often involved in prosthetic valve endocarditis although *Candida*, *Aspergillus*, diphtheroids, and a variety of gram-negative organisms are also seen.

D. Infections on prosthetic valves have different clinical and epidemiological features depending upon the time of onset.

E. All of the above

### 2. The following statement(s) is/are true:

- A. The frequency of cardiovascular prosthetic valve associated infections varies from 0.2 to 9.5%.

(Continued on page 45)

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## Hormone Manipulation in the Therapy of Human Malignant Disease a Symposium in Honor of Samuel G. Taylor III, M.D.

The Drake Hotel, Chicago  
April 15-16, 1980

### Program Objectives

- To provide an appreciation of the physiological basis for endocrine therapy in malignant disease with special emphasis on breast cancer;
- To review hormone manipulation and endocrine organ ablation in pre-menopausal and post-menopausal women with disseminated and local breast cancer;
- To discuss how therapeutic decisions with endocrine treatment modalities may be guided by hormone receptor assay studies;
- To review the use of additive hormone therapy in renal cell carcinoma, endometrial carcinoma and especially prostatic carcinoma.

### Faculty

Course Director: Jules E. Harris, M.D.

Charles B. Huggins, M.D.; Elwood V. Jensen, Ph.D.; B. J. Kennedy, M.D.; J. William Meakin, M.D.; Gerald P. Murphy, M.D., D. Sc.; Roar Nissen-Meyer, M.D.; Olof H. Pearson, M.D.; Arthur H. Rossof, M.D.; Albert Segaloff, M.D.; Robert E. Slayton, M.D.; Samuel G. Taylor IV, M.D.

### Rush Medical College

Section of Medical Oncology

Rush Cancer Center

For further information contact Mrs. Jean Davis, Rush Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 S. Paulina, Chicago. Ph: (312) 942-7095.



# 1979 ISMS State Fair Exhibit

BY JACOB E. REISCH, M.D./SPRINGFIELD

*Jacob E. Reisch, M.D., coordinates and directs the ISMS State Fair Booth. Dr. Reisch, who was named Honorary Past President of ISMS at the 1979 Annual Meeting, has served the Society since 1947. An active member and chairman of many ISMS Councils and Committees, he served as Secretary-Treasurer of the Society for 17 years.*

The '79 ISMS exhibit at the Illinois State Fair was most worthwhile. First, and most outstanding, it represented a milestone of 31 consecutive years of participation. In that time, the booth has brought medical information and education, plus, in recent years, a tangible service to and for the general public. It is an achievement of which all can be proud, since the presentations have always commanded interest and attention by thousands of Fair-goers.

The exhibit took on a double-barrel approach. First, it presented the dangers of alcohol abuse to the human body and the unborn. Secondly, it addressed high blood pressure, a treacherous disease and "silent killer." While both told tragic stories, assurance was given that preventive medicine and personal responsibility could greatly decrease attendant health problems.

Alcoholism education, sponsored by the Division of Alcoholism, Illinois Department of Mental Health and Developmental Disabilities, drew sharp focus on the hidden trauma which could be inflicted on the fetus by use of alcohol during the prenatal period, and the overall hazards to health resulting from chronic alcohol abuse. A revolving eight-foot trihedral tower dramatically portrayed, on one aspect, the alcoholic mother-to-be with the admonition "MAMA BOOZES, BABY LOSES," and, on the other two sides, sobering facts concerning the effects of maternal alcohol intake on the yet unborn infant. It impressed—and astounded—many. Tangentially, a 20-foot-wide illuminated AMA exhibit, complete with an electronic question-and-answer system, effectively visualized damage done to various organs of the body by excessive elbow-bending over a long period of time.

The overall impact of the alcohol presentation was not one of rapture or delight. The awed and amazed expressions on the faces of those viewing the displays of alcoholic-related pathology revealed that the medical lessons being projected were well understood.

In addition, one needed only to gaze slightly upward to see, suspended from the ceiling, a series of inverted 18-inch pyramids of poster-board, each carrying three shocking statistics on the results of alcohol abuse. There could be no mistaking of the fact that one of the Society's important messages of the day concerned the

dangers resulting from over-indulgence in alcoholic beverages.

The second phase of the exhibit was the State Medical Society's positive and direct contribution toward the betterment of health and preservation of life by helping Illinois citizens ward off the dangers posed by hypertension. During each day of the Fair, four blood pressure stations were kept constantly busy taking readings. The "hypertension screeners" were all medical students from the SIU School of Medicine at Springfield, who volunteered for this service. Working in three-hour shifts, the students recorded the reading on permanent blood pressure record cards supplied by the State Society. While no medical advice could be given, those with abnormal pressures were admonished to see personal physicians promptly for proper management. This service, started and enthusiastically accepted four years ago, has been continued for the many who return annually for a re-check of their pressure.

Thus, the organizations frequently described as ivory towers of medicine have attained a direct personal contact with the profession's most important element—the patient. The importance of medical societies no longer remains nebulous in the minds of many.

There were other features of the medical booth which amplified its effectiveness. A pocket Health Information Record card which has been made available by the Society for several years was still in high demand. Literature on various aspects of both alcoholism and hypertension was available. One pamphlet, a reprint of a previously designed four-page text on "How to Avoid the Silent Killer" was still popular, as well as another brochure explaining the meaning of blood pressure measurements. "Alcohol's Effect on the Unborn" and "Alcoholism: A Disease to Prevent, to Treat, to Understand," were two equally popular ISMS brochures.

There is no question but that this exhibit, during its 31 year's existence, has helped to improve and enhance the medical profession's liaison with the general public. One of its primary goals—closer public relations and mutual cooperation—is being achieved. Fair-goers are well aware that Illinois physicians are striving to improve the quality of health care for Illinois citizens. ◀

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- CHARGES & PAYMENTS



# Summary of Actions

## 1979 Interim Session

### House of Delegates

*The ISMS House of Delegates met November 10-11, 1979, and acted on resolutions and reports as described below:*

#### OLD BUSINESS

1. Defeated a resolution which called upon ISMS to conduct a proposed study and public relations campaign on the costs borne by physicians in complying with government programs and regulations. (78N-2)
2. Defeated a resolution directing ISMS to form a physicians' negotiating agency to arbitrate disagreements with third party payors. (78N-46)
3. Resolution 78N-1 considered in Reference Committee C.

#### REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

1. Accepted the following observations and objections as "an expression of feeling of the House of Delegates" regarding the Report of the AMA's Ad Hoc Committee on the Principles of Medical Ethics:
  - In order to avoid the implication that patients are secondary, the preamble to the proposed principles should indicate that a "physician must recognize responsibilities to patients first" and then to society, other health professionals and self.

- References to "other health professionals" are inappropriate in a code of physician's ethics and should be eliminated from the future principles. Such references now appear in items IV and V of the proposed principles.
- Specific wording to cover "fee splitting," "consultations," and "solicitation of patients" should be reinstated in the principles if they are to be revised.
- Concurrence that gender be eliminated from the Principles.

2. Acknowledged the need to amend the AMA Principles of Medical Ethics to provide for the legal rights of physicians to advertise appropriately and associate professionally with whom they wish, acknowledging always there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safe-guarding of confidence and service to mankind. (79N-34)
3. Directed that the membership be polled—through the constituent medical societies—regarding the report of the AMA Ad Hoc Committee on the Principles of Medical Ethics. The ISMS Board of Trustees was requested to develop an appropriate questionnaire for use by the county societies.

The House also encouraged individual members to submit their comments on the proposed revisions to the Ad Hoc Committee through AMA Headquarters. (79N-35)

4. Amended the Bylaws to restrict the business of the House of Delegates at the Interim Session to: (A) Resolutions and reports introduced by the Board of Trustees as urgent business; (B) Resolutions on matters of national importance and considered urgent introduced by a voting member of the House on behalf of the AMA delegation; and (C) Resolutions introduced by individual delegates, the Resident Physicians Section or Student Business Section, which are considered urgent and accepted by the Committee on Rules and Order of Business. Amendments further provide that decisions of the Committee on Rules and Order of Business regarding introduction of resolutions at the Interim Session may be overruled by a majority of the House of Delegates. Unaccepted resolutions will be carried over to the next annual meeting. The amended Bylaws define the Committee on Rules and Order of Business as a five-member Committee nominated by the Speaker and confirmed by the House at the annual meeting to serve for one year. Expanded responsibilities of that Committee include consideration of: (A) Late resolutions for introduction at the annual meeting; and (B) Resolutions introduced at the interim meeting by individual delegates, the Resident Physicians Section, or Student Business Session. (79N-6)
5. Amended the Bylaws to provide that delegates and alternate delegates to the AMA shall be: (A) Elected by the House of Delegates for two-year terms unless elected to fill a portion of another unexpired term; (B) Designated as officers of the Society; and (C) Given privilege of the floor in the House without vote, unless they are already voting members. (79N-7)
6. Amended the Bylaws to include the following direct reporting committees of the Board of Trustees: (A) Insurance; (B) Health Planning; (C) Drugs and Therapeutics; (D) Health Data; (E) Peer Review Appeals and (F) CME Accreditation. Deleted from the

Bylaws was the Ethical Relations Committee, which no longer exists. (79N-8)

## REFERENCE COMMITTEE A

1. Approved for use by component societies the Judicial Panel's Handbook for the Conduct of Disciplinary Proceedings. However, the House directed the Judicial Panel to "confine all future decisions to its proper appellate function which is to sustain, remand, overturn or reduce a decision rendered by a county society or district ethical relations committee. (79N-2,22)
2. Directed that responsibilities of the ISMS president, chairman of the board and president-elect, as described in the Ad Hoc Committee on Internal Affairs report, be referred back to the Ad Hoc Committee for preparation of appropriate bylaw amendments for consideration by the House at its next annual meeting. (Ad Hoc Committee on Internal Affairs Report)
3. Defeated a resolution calling for creation of a new position, chairman-elect of the Board of Trustees. The proposal also mandated a compulsory succession of offices from chairman-elect to president. (79N-5)
4. Rejected a proposal calling upon AMA to amend its Principles of Medical Ethics to include criterion for physician billing practices. (79N-9)
5. Reiterated its opposition to third party payor determination of medical necessity, including hospitalization, over and above the treating physician's judgment and:
  - Directed ISMS to inform the Ill. Legislature of its opposition to medical necessity provisions in the Blue Cross/Blue Shield contracts . . . and request the Ill. Department of Insurance to disapprove them.
  - Urged the utilization of peer review mechanisms to arbitrate medical necessity disputes.
  - Directed the Illinois AMA Delegation to communicate these decisions to the AMA House of Delegates and seek its active



support for them on a national level with respect to the Federal Employees Program.

- Affirmed that the Society's opposition applies not only to the BC/BS contract certificates and riders which provide for third party payor determination of medical necessity, but to any group or individual contract, certificate, rider, or any other instrument which provides for third party payor determination of medical necessity. (79N-14, 15, 16)
- 6. Ratified emergency Board of Trustees action modifying the ISMS dues billing to avoid future legal problems and supported IMPAC action to provide that the \$45 voluntary contribution to IMPAC: (A) Represents a family membership in IMPAC for support of Illinois candidates at all levels; and (B) Provides for a contribution to AMPAC—in an amount specified by IMPAC—to be used at AMPAC's discretion in support of candidates for federal office elsewhere. IMPAC legal counsel was directed to confer with AMPAC consultant legal counsel to resolve any differences regarding transfer of funds from IMPAC to AMPAC. (79N-31)
- 7. Referred to the Board of Trustees for study and report at the 1980 annual meeting a resolution calling for a \$3.00 per member dues assessment to jointly support activities of the Resident Physician Section and Student Business Section. (79N-44)
- 8. Directed that the RPS and SBS chairpersons be invited to submit a report at each meeting of the ISMS Board of Trustees, with the understanding that they will present their report in person, with their travel expenses paid. (79N-46)
- 9. Approved the concept of allowing a person other than a physician licensed to practice medicine in all its branches to be appointed Director of the Illinois Department of Public Health provided that no qualified physician can be found and that a Medical Policy Board composed only of seven physicians—2 public health physicians, 2 medical school physicians and 3 practicing physicians—all licensed to practice medicine in

all its branches, be created by statute to guide and direct the director in all medical matters. (79N-50)

10. Resolution 79N-45, regarding county medical society orientation sessions, was withdrawn by the sponsor.

## REFERENCE COMMITTEE B

1. Directed the Board of Trustees to carefully monitor negotiations with the Illinois Department of Public Aid regarding: (A) Patient record confidentiality; (B) IDPA administrative practices; (C) Psychiatric medical benefits; (D) Exception review program; and (E) Audit activity.

The Board also was directed to:

- Submit reports on these negotiations at all subsequent meetings of the House of Delegates until all issues have been resolved;
  - Initiate appropriate legal or administrative action if it determines that negotiation has ceased to be an effective manner in which to redress grievances. (79-N10, 11, 12, 18, 20, 26)
2. Reaffirmed endorsement of CPT-4 for IDPA billing purposes. Directed the Board of Trustees to rescind its approval of a condensed version of that code proposed by IDPA. (79N-36)
  3. Reaffirmed opposition to use of the Social Security Number for IDPA provider invoices and suggested that IDPA either assign its own number for these purposes or utilize the state medical license number. Declined to delete from the ISMS Policy Manual the statement opposing use of the Social Security Number as a universal number identifier. (79N-21, 33)
  4. Encouraged development of local joint committees of county medical societies and county health departments to review current and proposed public health projects. Directed the Board of Trustees to develop a policy statement to be presented to the House at its next meeting which will de-

lineate the proper activities for local and state health departments. (79N-28)

5. Directed that ISMS urge the federal government to add appropriate interest—beginning 60 days after claim filing—to all Medicare payments issued to patients and to physicians. Instructed the Illinois AMA Delegation to support similar action by the AMA House of Delegates. (79N-49)

## REFERENCE COMMITTEE C

1. Directed ISMS to assist medical students by: (A) Disseminating information on loans available at reasonable rates; and (B) Initiate with financial institutions new methods of generating reasonable loan funds and scholarships. (79N-32)
2. Directed the Society to investigate development of an emergency loan fund designed to aid first-year residents in the event of closure of a training hospital or dissolution of a training program. (79N-38)
3. Ratified Board of Trustees' decision to send CME accreditation reports only to the AMA and instructed the Illinois AMA delegation to encourage efforts toward elimination of dual CME accreditation at the national level. (79N-47)
4. Adopted a policy that would encourage: (A) Medical School admissions be determined on the basis of ability and merit; and (B) Physicians, both in-training and in practice, to serve in areas with physician shortages. (78N-1)

## REFERENCE COMMITTEE D

1. Ratified Board Trustees' action deleting from the ISMS advertising guidelines the statement "advertising by radio, television or bill-board is prohibited." (79N-4)
2. Opposed national compulsory catastrophic health insurance as financially irresponsible and urged AMA to: (A) Adopt the same position; and (B) Continue to support pri-

vate, voluntary catastrophic health insurance. (79N-24)

3. Supported study of proposals and legislation designed to provide long term solutions to problems in providing appropriate local institutional health care services to the medically indigent and "working poor." (79N-39)
4. Authorized the Board of Trustees to: (A) Continue to study the concept of developing an alternative health insurance carrier for Independent Practice Associations in Illinois; and (B) Pursue sources of funding and identify other essential matters in order that a specific plan of action may be presented to the House of Delegates at a later date. Expenditures of the study will be limited to the \$50,000 already committed. (79N-40)
5. Supported all efforts to ban or restrict smoking in all public places and development of appropriate regulations to that end. (79N-41)
6. Defeated a resolution calling for a reduction in the sale, importation, production, transfer and availability of handguns because the intent of the resolution is met in the ISMS Policy Manual statement on violence. (79N-42)
7. Supported legislative efforts to ban all cigarette advertisements and encouraged anti-smoking campaigns in the media. (79N-43)
8. Supported the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and instructed the Illinois AMA Delegation to introduce a similar resolution at the next meeting of the AMA House of Delegates. (79N-48)

## SPECIAL ACTIONS

1. Expressed profound loss and condolences to the family of Anna A. Marcus, M.D., recently deceased. Declared that Dr. Marcus, a member of the House of Delegates, had been "a devoted, active, able and effective participant in the affairs of this Society," and that her death had caused "a void in our ranks and in our hearts."



# Actions on Resolutions

## November, 1979, Interim Meeting

### House of Delegates

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
<b>Old Business</b>			
78N-2 (BOT Report C)	M. Barry Kirschenbaum, M.D.	Government Influence on Cost of Medical Care	Not Adopted
78N-46 (BOT Report D)	George T. Wilkins, M.D.	Physicians' Negotiating Agency	Not Adopted
<b>Reference Committee On Constitution &amp; Bylaws</b>			
79N-6	Cyril C. Wiggishoff, M.D.	Amendments to Chapters IV and IX of the ByLaws	Substitute Adopted as Editorially Changed
79N-7	Cyril C. Wiggishoff, M.D.	Amendments to Chapters IV, V and VI of the ByLaws	Adopted as Editorially Changed
79N-8	Cyril C. Wiggishoff, M.D.	Amendments to Chapter IX of the ByLaws	Adopted
79N-34	H. Herbolsheimer, M.D.	Expansion of 1978 Action on Medical Ethics	Adopted as Editorially Changed
79N-35	H. Herbolsheimer, M.D.	Report of the AMA's Ad Hoc Committee on Principles of Medical Ethics	Substitute Adopted as Amended
<b>Reference Committee "A"</b>			
79N-2	Lawrence L. Hirsch, M.D.	ISMS Judicial Panel	Adopted
79N-5	C. J. Jannings, M.D.	ByLaws Revision	Not Adopted
79N-9	D. O. Chamberlain, M.D.	Likely Untoward Reaction of the Public to Unfair or Careless Charges by a Few Physicians Leading to the Condemnation of All	Not Adopted
79N-14	David A. Rothstein, M.D.	HCSC Group Master Contract & Group Master Certificate	Adopted and Referred to BOT for Immediate Action

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
79N-15	David A. Rothstein, M.D.	Medical Necessity in Third Party Contracts	Adopted
79N-16	David A. Rothstein, M.D.	Medical Necessity & Peer Review	Adopted
79N-22	Frank B. Norbury, M.D.	Handbook for the Conduct of Disciplinary Proceedings	Adopted
79N-31	Robert R. Hartman, M.D.	Modification of Dues Statements	Adopted as Amended & Editorially Changed
79N-44	David Whitney William Golden, M.D.	Increased Funding for ISMS/SBS and ISMS/RPS	Referred to BOT for Further Study & Report Back to HOD at Next Annual Meeting
79N-45	David Whitney William Golden, M.D.	County Medical Society Orientation Sessions	Withdrawn
79N-46	David Whitney William Golden, M.D.	Resident & Student Ex-Officio Positions on Board of Trustees	Substitute Adopted
79N-50	Lawrence L. Hirsch, M.D.	Non-M.D. Director of Public Health	Substitute Adopted as Amended
<b>Reference Committee "B"</b>			
79N-10	Lawrence L. Hirsch, M.D.	Release of Medical Records Without Patient Permission	Substitute Adopted
79N-11	Lawrence L. Hirsch, M.D.	Arbitrary Administrative Procedures of the Ill. Department of Public Aid	Substitute 79N-10 Adopted in Lieu of 79N-11
79N-12	Lawrence L. Hirsch, M.D.	Illinois Department of Public Aid Reimbursement for Psychiatric Care	Substitute 79N-10 Adopted in Lieu of 79N-12
79N-18	Finley Brown, M.D.	Exception Review Program	Substitute 79N-10 Adopted in Lieu of 79N-18
79N-20	Finley Brown, M.D.	Provider Invoice DPA Form 1443	Substitute 79N-10 Adopted in Lieu of 79N-20
79N-21	Finley Brown, M.D.	Social Security Number	Adopted as Amended
79N-26	Finley Brown, M.D.	Unprofessional Auditors	Substitute 79N-10 Adopted in Lieu of 79N-26
79N-28	Thomas C. Bunting, M.D.	Review and Support or Withdrawal of Support for Public Health Dept. Projects	Substitute Adopted as Amended



<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
79N-33	Allan L. Goslin, M.D.	Deletion of Statement on Social Security Number as a Universal Number Identifier from Policy Manual	Not Adopted
79N-36	S. J. Rousonelos, M.D.	CPT-4 Condensation	Adopted
79N-49	Morris T. Friedell, M.D.	Interest for Delayed Medicare Payments	Adopted as Amended
<b>Reference Committee "C"</b>			
Old Business 78N-1 (BOT Report E)	M. B. Kirschenbaum, M.D.	Medical School Admissions & Physician Shortage Areas	Substitute Adopted as Editorially Changed
79N-32	David Whitney	ISMS Support & Investigation of Low Cost Loans for Medical Education	Adopted as Amended and Editorially Changed
79N-38	William Golden, M.D. David Olive, M.D.	Emergency Loan Fund for Cook County Hospital Residents	Adopted
79N-47	David S. Fox, M.D.	National CME Accrediting Authority	Adopted
<b>Reference Committee "D"</b>			
79N-4	Morris T. Friedell, M.D.	Revised Advertising Guidelines	Adopted
79N-24	Morgan M. Meyer, M.D.	Catastrophic Health Insurance	Adopted as Amended
79N-39	William Golden, M.D. David Olive, M.D.	Supporting Concept of County Hospitals	Substitute Adopted
79N-40	P. John Seward, M.D.	IPA (Independent Practice Association)	Substitute Adopted
79N-41	David Whitney	ISMS Support for Banning or Restricting Smoking in Public Places	Adopted as Amended
79N-42	David Whitney	ISMS Support for Gun Control	Not Adopted
79N-43	David Whitney	ISMS Support for Banning Cigarette Advertisements	Adopted as Amended
79N-48	J. Waller, M.D.	Tax Credit for Premium Cost of Catastrophic Medical Pay Insurance	Substitute Adopted

**The Following Resolution Considered By The House Of Delegates Without Referral**

Lawrence L. Hirsch, M.D.	Memorial Resolution Anna A Marcus, M.D.	Adopted
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## Interim Session Highlight

# *Public Affairs Reception Hosts State Senate President*

Among many informative features of the 1979 Interim Session House of Delegates, held November 10-11 in Decatur, was a Public Affairs Reception for attendees.

State Senate President Philip J. Rock (D-Oak Park) addressed a group of about 200 physicians and their spouses, concerning current legislative issues and the ISMS Key Man Program.

ISMS Key Men are physicians or spouses who volunteer to keep their representatives in the Illinois legislature informed about legislative issues affecting the practice of medicine and the health of Illinois citizens. Sen. Rock pointed out that the contribution of technical expertise by these physicians can provide crucial insight to complex health issues.

On the general issue of personal involvement in the political process, Sen. Rock urged active participation: "There is nothing more effective," he said, "than a weekend phone call or visit to

the district office by one who is respected in the community."

The senator also digressed with amusing and lucid insights into the life of elected officials. The trend to view inexperienced politicians as preferable to those whose ideals caused them to seek office at a young age, he said, could be compared to a preference for health care from persons with no medical background. On another topic, he noted, "If politicians were criminals and the press were the police, I submit to you that the American Civil Liberties Union would come to their defense."

Reiterating that "individual involvement defines the calibre of government in Illinois," Sen. Rock opened the floor to questions. Topics ranged from accessibility of elected officials to proposed abolition of the cumulative voting system for Illinois' legislative districts. The open exchange was enjoyed by all present.



(L-R) John J. Ring, M.D., first district trustee, Sen. Philip J. Rock and Frank J. Jirka, Jr., M.D., former ISMS president and honorary delegate to the AMA.





(L-R) Mary Obrzut, Martin W. Green, M.D. ISMS delegate and one of Sen. Rock's key men, Sen. Philip J. Rock and Robert R. Hartman, M.D., chairman, ISMS Board of Trustees.



(L-R) Henrietta Herbolzheimer, M.D., ISMS trustee from the third district, P. John Seward, M.D., ISMS president, Sen. Philip J. Rock and Robert R. Hartman, M.D., chairman, ISMS Board of Trustees.

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# Surgeon General's Advisory

By Julius B. Richmond, M.D.

*The following article was circulated by the U.S. Surgeon General, Julius B. Richmond, M.D., for the benefit of physicians. The ISMS Board of Trustees has reviewed the item and found it to be of sufficient merit to authorize publication in IMJ as an educational and informational aid to the membership.*

Recent events have highlighted the importance of physicians and health professionals giving greater attention to possible dangers of prescribing certain drugs to individuals who abuse alcohol. During the past several years there has been a major increase in this country in the medical and non-medical use of drugs. Concurrently, the wide use of alcohol by both men and women enhances the probability that alcohol and another drug will act simultaneously in many individuals, with serious and potentially fatal consequences. Indeed, alcohol use in combination with other drugs accounts for approximately 20 percent of the total number of accidental and suicidal deaths per year which are drug-related.

Concern over these trends prompts me to alert the medical profession to the special problems of prescribing certain drugs for patients who consume alcohol.

I wish to remind all physicians and health professionals that:

- many commonly prescribed drugs have altered therapeutic and/or adverse medical effects when taken with alcohol. These drugs include not only sedatives, hypnotics, narcotics, antidepressants and tranquilizers, but also certain antihistamines, analgesics, anti-coagulants and anti-infective agents.
- minor tranquilizers as well as other CNS depressants are frequently used by patients in combination with alcohol despite warnings to the contrary. This combined use may produce adverse medical consequences. Moreover, the resultant potentiation of CNS depression can impair performance of tasks requiring alertness—such as driving—increasing the likelihood of injury and even

death. The combination itself can lead to death by accidental overdose or by suicide.

- the use of marijuana and other illicit psychoactive substances is widespread, and this use often occurs in combination with alcohol, or other licit psychoactive drugs.

Therefore, I urge all physicians and health professionals to:

- (1) routinely document the history and scrutinize the pattern of alcohol consumption for individual patients to determine the possible relationship between presenting complaints and mixing drugs with alcohol;
- (2) be alert to the possible interaction of prescribed, over-the-counter, or illicit drugs singly or in combination with alcohol;
- (3) pay careful attention to the section in the package insert that deals with drug-alcohol interactions and consult the current medical literature and references for specific problems;
- (4) limit as much as is practical the quantity of drugs dispensed with any one prescription and monitor the patient with regular follow-ups for unexpected reactions to the medication;
- (5) consider, both in the choice of therapy and in the evaluation of the patient, the likelihood of the patient's adherence to your admonition (and that of warning label on the prescription) against using alcohol while taking medication. ◀



## EKG

(Continued from page 31)

Answers: 1. C.D. 2. E.

The ECG rhythm strip shows severe or high grade AV block with occasional sinus capture beats. The third and eighth beats in line one, the fourth beat in line two, all with a PR interval of 0.44 seconds, and probably the second beat in line three with a PR interval of 0.52 seconds, are sinus capture beats. Careful analysis of the rhythm strip will demonstrate sinus P waves at a rate of 100/minute and a junctional rhythm with a rate of 54/minute as well as the above sinus capture beats. This is incomplete AV dissociation because of high grade AV block and the occasional sinus capture beats. All of the statements in question two are true. Fortunately, endocarditis involving a prosthetic valve is uncommon. When it does occur, it carries a high mortality rate. The frequency of infection is greater in high pressure systems with turbulent flow such as the aortic valve area. Infections that occur early, less than 60 days after surgery, arise most often from surgical contaminations. Those infections that occur late, more than 60 days after surgery, are related to bacteremias such as are associated with surgical manipulations, *i.e.*, dental work or genitourinary surgery. The clinical findings are similar to those found in any patient with bacterial endocarditis: embolic phenomena, anemia, splenomegaly, subungual hemorrhages, conjunctival petechiae, and especially regurgitant murmurs involving the prosthetic valve. The high grade AV block seen in our patient led us to suspect that the aortic annulus was involved by abscess or inflammation despite antibiotic therapy. This was indeed found to be the case when subsequent surgery was performed to replace the infected prosthetic aortic valve. For further reading, see Bennett and Brachman, editors, *HOSPITAL INFECTIONS*, Little Brown and Company, Pub., 1979. ◀

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# Seminars in Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

## Immunofluorescence Tests

### Pemphigus and Bullous Pemphigoid

ROBERT E. JORDON, M.D., AND SUSAN E. MACKEL, M.D./MILWAUKEE, WISCONSIN

*Pemphigus and bullous pemphigoid are autoimmune diseases which effect the skin. Autoantibodies, specific for skin and mucosal antigens, are present in both conditions and are the basis for several useful diagnostic immunofluorescence (IF) tests.<sup>1,2</sup> These IF tests have led to a better classification of the vesiculobullous skin diseases of man, while allowing us to differentiate one from another. This brief review will discuss two of the vesiculobullous diseases, pemphigus vulgaris and bullous pemphigoid, and point out the usefulness of IF tests in diagnosis and management of these conditions. Illustrative cases are included.*

The following cases illustrate two varied clinical presentations of pemphigus vulgaris. In case one, oral involvement was followed shortly by typical cutaneous lesions, and a diagnosis of pemphigus was suspected early in the course of the disease process. However, the patient illustrated in case two was treated for several months for aphthous stomatitis. Because of her young age and the limited involvement, pemphigus was suspected only when bullae and more extensive mu-

cosal involvement were apparent. The skin remained clear. The diagnosis of pemphigus vulgaris was confirmed in both cases by histopathologic examination as well as IF studies.

#### Case One

A 73-year-old female first reported rapid onset of a sore throat and difficulty in swallowing. She was treated with mouthwashes and a systemic antibiotic without relief. Two weeks later, crusting lesions of the lips, groin, and inframmary region were noted. A diagnosis of pemphigus vulgaris was considered and she was admitted to the hospital for evaluation one month after initial symptoms.

Physical examination found well-demarcated erythematous crusting plaques in the inframmary region, groin, and back (Figure 1). Crusted eroded lesions of the upper and lower lips and superficial erosions of the hard palate, tongue and buccal mucosa were present, as well as bilateral

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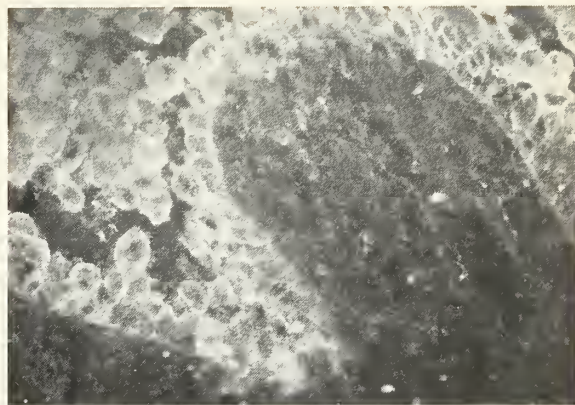
SUSAN E. MACKEL, M.D., is a fellow of the U.S. Public Health Service. Both Dr. Jordan and Dr. Mackel conducted this work through the Cutaneous Immunopathology Unit and Research Service, Veterans Administration, Milwaukee, Wisconsin and section of dermatology, department of medicine, Medical College of Wisconsin.





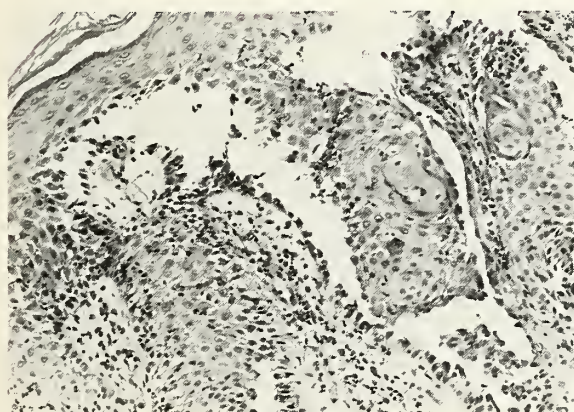
**Figure 1**

Back of patient from case one demonstrating erythematous crusting plaques.



**Figure 3**

Direct IF of specimen from patient one demonstrating intracellular deposition of C3.



**Figure 2**

Histologic section of biopsy from patient one demonstrating intraepidermal bulla formation just above the basal layer. Acantholytic cells can be seen within the bulla. (hematoxylin-eosin)

conjunctivitis. Laboratory studies indicated a normal CBC, SMA-12, chest X-ray film and EKG. Urinalysis revealed pyuria and bacteriuria, and *Proteus mirabilis* was cultured. Histopathologic examination of an early lesion showed epidermal suprabasilar acantholysis with a mixed cellular infiltrate in the papillary dermis (Figure 2). Direct IF studies demonstrated epidermal intercellular deposits of IgG and C3 (Figure 3). Serum for indirect IF demonstrated intercellular substance (ICS) antibodies at a 1:80 dilution. A diagnosis of pemphigus vulgaris was established and treatment with prednisone 200mg/day resulted in a gradual resolution of the inframmary and groin lesions. The oral lesions remained un-

changed for several weeks, then showed slow improvement when triamcinolone acetonide in water/oil base was used. Chloroptic ophthalmic solution was prescribed for the conjunctivitis and the urinary tract infection was treated with Ampicillin. The patient was followed in the dermatology clinic for several months during which time the prednisone was tapered to 40mg q.o.d., and azathioprine 50mg b.i.d. was added. The skin remained clear and indirect IF titer became negative.

The patient was readmitted to the hospital five months after first admission with a temperature of 101.2°F and a two day history of pain and decreased range of motion in the right shoulder. *Staphylococcus aureus* was cultured from both the shoulder aspirate and the blood. Her infection responded to treatment with Nafcillin but a recurrence of fever and decreasing renal function after one week indicated the development of interstitial nephritis. Clindamycin was substituted with rapid resolution of the infection. During this hospitalization, the skin remained clear but the oral mucosa was injected and ulcerated.

For eleven months the patient did well while receiving prednisone 40mg q.o.d. and azathioprine 50mg b.i.d. Then, however, the indirect IF titer increased to 1:640. A month later, the patient noted the appearance of new pruritic and painful lesions on the right flank. On physical examination, grouped vesicles on an erythematous base were found on the right flank in a dermatomal distribution typical of the lesions of herpes zoster. New bullae on the back and breasts, oral ulcerations, and conjunctivitis also soon developed. Topical therapy with wet compresses was

**TABLE 1**  
**PEMPHIGUS GROUP**

*Pemphigus vulgaris*  
*Pemphigus vegetans*  
*Pemphigus foliaceus*  
*Pemphigus erythematosis*  
*Fogo selvagem*

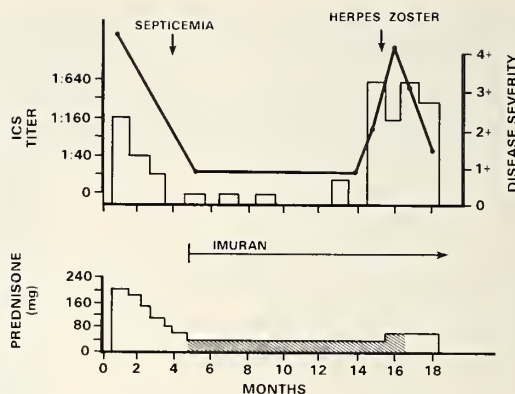
instituted and the prednisone was increased to 60mg q.d. On this regimen the skin lesions cleared within several weeks.

### Case Two

A 25-year-old woman had a one year history of recurrent oral ulcerations. She was thought to have aphthous stomatitis and had received topical medications (nystatin oral solution, triamcinolone acetonide in water/oil base, and tetracycline hydrochloride mouthwash) with only brief remissions. Indirect IF was first performed during a severe exacerbation with ulcerative desquamation and bullae of her tongue, lower lip, tonsillar pillars, and buccal mucosa, as well as vaginal ulceration. The indirect IF demonstrated the presence of ICS antibodies with a titer of 1:320. Direct IF demonstrated epidermal intercellular deposits of IgG, IgM, C3 and fibrin. Histopathologic examination of a fresh oral bulla was diagnostic of pemphigus vulgaris. Other laboratory values included a leukocyte count of 4,900/cu mm with 11.5% eosinophils. Urinalysis, chest X-ray film, serologic test for syphilis, lupus erythematosus clot test, and erythrocyte sedimentation rate were normal. Treatment with prednisone 50mg/day was instituted and was gradually tapered to 10mg q.o.d. over the following year. On this regimen, all lesions cleared and the indirect IF remained negative.

### Comment

*Pemphigus vulgaris*, which both of these cases represent, is a member of the pemphigus group of diseases (Table 1). Other members of the group include pemphigus vegetans, pemphigus foliaceus, pemphigus erythematosis and Brazilian pemphigus foliaceus or "fogo selvagem." Histologically, all of the variants are characterized by intraepidermal bulla formation, dissolution of the intercellular cement substance, and loss of cohesion of individual epidermal cells, a process referred to as "acantholysis".<sup>2</sup> Likewise, all forms of pemphigus are also characterized by the presence of autoantibodies reactive with an inter-



**Figure 4**

Graph correlating indirect IF titer with disease severity and treatment in patient one. Shaded areas represent alternate day steroid therapy. Elevation of indirect IF titer and an increase in disease severity during herpes zoster infection is illustrated.

cellular substance (ICS) of skin and mucosal epithelium as demonstrated by indirect IF staining.<sup>1-4</sup> These antibodies interact with antigens located at the precise sites of the primary histopathologic lesion, *i.e.*, the intercellular areas. Unequivocal evidence has now been presented from three different laboratories; these autoantibodies are responsible for the characteristic acantholytic changes seen in pemphigus lesions.<sup>5-7</sup>

*Pemphigus vulgaris* and pemphigus vegetans are deep forms of the disease with epidermal clefting occurring in the suprabasilar region (Figure 2). Pemphigus foliaceus, pemphigus erythematosis and fogo selvagem, on the other hand, represent superficial forms of the disease process with acantholysis occurring in or near the granular layer. Despite these histologic differences, ICS reactive antibodies are found in all forms of pemphigus and are considered a diagnostic hallmark for the group.

As case one illustrates, levels of pemphigus antibodies often parallel and reflect activity of disease.<sup>8,9</sup> That is, levels of these antibodies are high during periods of disease activity and are low or absent during periods of remission. In our patient (Figure 4), antibody levels were relatively high during the initial episode of pemphigus vulgaris. With control of her blistering, antibody levels fell and disappeared during a period of remission. Following an episode of herpes zoster, antibody levels rose dramatically, and within two weeks of this rise, she had a severe relapse of her disease process. With control of this severe exacerbation, her antibody levels have





**Figure 5**

Typical tense bullae and crusting lesions on flexor surfaces of patient three.

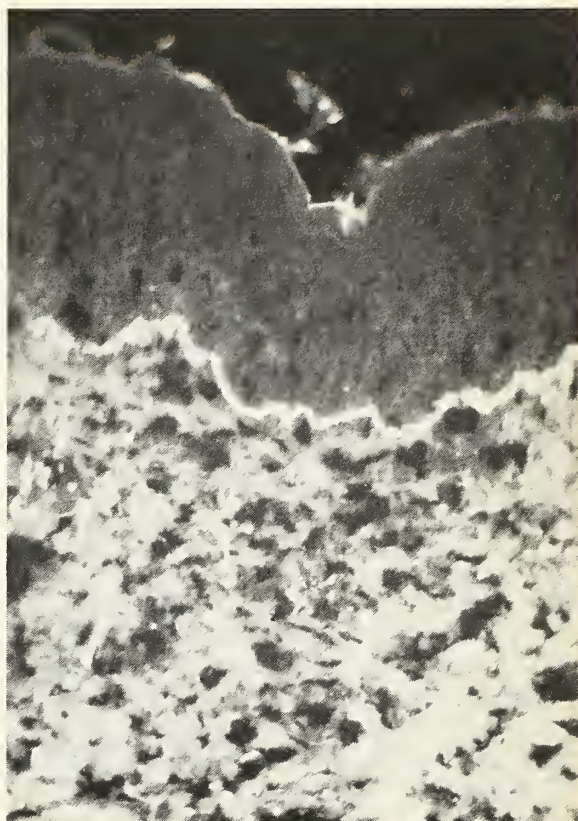


**Figure 6**

Histologic section of biopsy from patient three demonstrating subepidermal bulla filled with fibrin and neutrophils and a superficial perivascular infiltrate of neutrophils and lymphocytes. (hematoxylin-eosin)

again begun to diminish. Frequently, antibody levels rise preceding a flare, as depicted here, and usually they persist for a time in early remission. Exceptions to this rule, however, do occur. In some patients, levels of antibodies remain high despite lack of clinical activity.<sup>10</sup> Circulating antibodies are sometimes not detectable despite widespread lesions.<sup>2</sup> Some of these latter cases may be partially explained by the presence of immune complexes;<sup>11</sup> the antibodies are present but complexed, and are not free to be detected by routine IF methods.

Direct IF staining of lesional material is extremely valuable in evaluating patients with suspected pemphigus. IgG deposition in the ICS areas, a pattern identical to that seen using indirect IF staining, is apparent in most skin lesions



**Figure 7**

Indirect IF of serum from patient three demonstrating IgG deposition along the BMZ.

and is highly diagnostic of pemphigus.<sup>2,12</sup> Complement deposition is also present in early skin lesions, especially in areas of acantholysis.<sup>13</sup> It should be noted that direct IF for ICS deposition of IgG and C3 will be positive early in the disease process and at times when the antibody is not present in the serum. As with routine histopathology, the best choice for an IF biopsy in pemphigus is an early fresh small blister.

Oral lesions are often the earliest manifestation of pemphigus vulgaris. Recently, a series of patients with the disease confined entirely to the oral cavity has been reported.<sup>14</sup> Case two is one of these patients. More common oral diseases such as aphthous stomatitis, desquamative gingivitis, herpes stomatitis and erythema multiforme are usually considered first. The diagnosis of pemphigus vulgaris, however, is easily established if the physician's level of suspicion is sufficiently high. In cases of persistent oral lesions, biopsies of oral tissue, for both routine histopathology and direct IF, should be performed.



A number of other acantholytic diseases, including Hailey-Hailey disease, Darier's disease and Grover's disease, have also been investigated using direct IF staining. In this laboratory's experience, none of these conditions manifest positive IF despite the presence histologically of acantholysis.

### **Bullous Pemphigoid**

The patient in case three typifies the clinical presentation of bullous pemphigoid. Again, histopathologic and IF studies permitted the rapid diagnosis of this bullous disease.

### **Case Three**

A 67-year-old man was admitted to the hospital with a three week history of an erythematous rash which was first noted on the upper inner thighs. Two days prior to admission, lesions began appearing on the trunk, neck, face, and upper extremities. On physical examination, abnormalities were limited to the skin.\* Multiple tense 5-10mm vesicles and bullae on erythematous bases were found, primarily on the inner surface of the arms and in the groin, with a few scattered lesions on the trunk and lower extremities (Figure 5). The oral mucosa was clear. Normal or negative laboratory studies included a CBC, SMA-12, serologic test for syphilis, chest X-ray film and EKG. Urinalysis revealed proteinuria and pyuria, and *E. coli* was cultured. Histopathologic and IF studies of skin specimens were performed. Histologically, a subepidermal bulla containing fibrin and neutrophils, and a superficial perivascular infiltrate of neutrophils and lymphocytes was noted (Figure 6). On direct IF, IgG and C3 were detected at the basement membrane zone (Figure 7). Indirect IF for circulating IgG autoantibodies in the patient's serum was positive at a titer of 1:160. A diagnosis of bullous pemphigoid, therefore, was established.

On the day following admission, occult blood was detected in an emesis and stool and the hematocrit fell from 44% to 34% over the next few days. Due to the possibility of an active ulcer, oral steroids were withheld and the patient was treated with topical steroids and compresses as well as Dapsone 100mg/day. He also received an antibiotic for a urinary tract infection and antacids. New erythematous macules and papules as well as bullae on the palms and dorsal hands were noted despite increases to 200mg/day Dapsone. After an extensive examination of the gastrointestinal tract, the patient was found to have a hiatal hernia with esophagitis. The Dap-

**TABLE 2**  
**PEMPHIGOID GROUP**

Bullous pemphigoid  
Cicatricial pemphigoid  
Localized pemphigoid  
(Brunsting-Perry Type)  
Bullous dermatosis of childhood  
Herpes gestationis

sone was discontinued and prednisone 80mg/day was started. No new lesions appeared while on systemic steroids. One month after discharge the prednisone had been tapered to 100mg/q.o.d. and azathioprine 50mg/b.i.d. was started. Over the next year the prednisone was decreased to 15mg/q.o.d. without exacerbation of his disease.

### **Comment**

Bullous pemphigoid is a member of the pemphigoid group of diseases (Table 2). Others in the group include cicatricial pemphigoid, localized scarring pemphigoid (Brunsting-Perry), chronic bullous dermatosis of childhood, and herpes gestationis. Listing these diseases collectively as the pemphigoid group in no way implies that these conditions are one and the same, but is based upon similar histopathologic and IF findings, in addition to some clinical overlap. Only bullous pemphigoid, however, will be considered here.

Case three represents a typical presentation for bullous pemphigoid. It is a disease process confined mainly to the sixth, seventh and eighth decades of life. Typical lesions are large tense blisters with a predilection for the flexural surfaces (Figure 5).

Histopathologically, bullous pemphigoid is a subepidermal blistering skin disease, a feature shared with other members of the pemphigoid group, dermatitis herpetiformis and erythema multiforme. Typically, total separation of the epidermis from the dermis is apparent. Atypicality, however, is common, including stuffing of the dermal papillae with neutrophils and eosinophils, a pattern usually associated with dermatitis herpetiformis. In one large series recently reported of bullous pemphigoid patients,<sup>15</sup> the histopathology was misdiagnosed as dermatitis herpetiformis in about one third of the cases. IF techniques are superior to routine histopathology (and are more specific) in separating bullous pemphigoid and dermatitis herpetiformis.



By indirect IF staining, autoantibodies reactive with a component of the basement membrane zone (BMZ) of skin and mucosa occur in this disease. Approximately 70% of patients with active bullous pemphigoid will manifest this antibody in serum; its presence is highly diagnostic of bullous pemphigoid.<sup>1,2,16</sup> Since this BMZ-reactive antibody is not demonstrable in as many as 30% of active cases, its absence certainly does not rule out the diagnosis. Unlike pemphigus vulgaris, antibody titers in bullous pemphigoid do not appear to parallel disease activity.<sup>8</sup>

Direct IF staining tests, however, are positive in virtually 100% of active cases of bullous pemphigoid. Because of the nature of this blistering process (*i.e.*, subepidermal bulla formation with total separation of the epidermis and

dermis) perilesional skin is the best choice for an IF biopsy. IgG is the most frequently bound class of immunoglobulins.<sup>2,12</sup> Others, including IgA, IgM, IgD and IgE all have been detected but less frequently.<sup>12,17-19</sup> C3 deposition occurs in virtually all bullous pemphigoid skin lesions; at times only C3 deposition is observed.<sup>2</sup> Other complement components, including classical pathway components (C1q and C4) and alternative pathway components (properdin and factor B), are also found deposited along the BMZ.<sup>17,18</sup> Using *in vitro* complement staining, the antibody found in the serum of bullous pemphigoid patients will fix these same components to normal skin BMZ.<sup>20,21</sup> The complement system, therefore, may be important in the pathogenesis of this interesting skin disease. ◀

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# Abstracts of Board Actions

(Continued from page 7)

## PUBLIC HEALTH

The Illinois Department of Public Health will provide influenza vaccine to local health departments for use in public clinics and long term care facilities. IDPH is urging use of the vaccine throughout the flu season which extends through April. The vaccine is intended for persons age 65 or older and persons with chronic disease. While no charge may be made for the vaccine, physicians may charge for the service. ISMS will support the immunization program, but: (1) Inform IDPH that the decision of whether or not to immunize the patient must rest with the individual's physician who knows the patient best; and (2) Urge IDPH to clarify its instructions to physicians who order the vaccine.

The Society will seek legislation that would provide IDPH with funds and personnel needed to conduct a retail food inspection program in areas not served by local health departments. IDPH discontinued its statewide inspection program in July, citing the lack of funds and personnel to examine each of the state's 10,000 restaurants more than once every six years.

## FINANCES

The Board rejected a suggestion that "ISMS share half of each member's first full year's dues with county medical societies to offset new member solicitation and processing costs" because it would jeopardize the five-year dues maintenance plan endorsed by the House of Delegates in 1978 and possibly require a dues increase earlier than originally planned. However, the Board directed: (1) Appointment of a committee to study membership recruitment activities and expenses and submit an interim report at the next Board meeting; and (2) Distribution of a newly-developed brochure outlining ISMS membership benefits and services to the full membership early next year. In other actions involving finances, the Board voted to:

- Extend to the ICCME Board of Directors and its committees the Society's \$50,000 business accident insurance coverage.
- Set a policy that—when an individual uses a private plane for Society business—the maximum allowable reimbursement shall equal the cost of ground or commercial coach airfare. Requests for reimbursement exceeding this limit will be considered by the Finance Committee.

## '81 INTERIM MEETING

The Board accepted an invitation from the Sangamon County Medical Society to hold the 1981 Interim Session of the House of Delegates in Springfield. The Board regretfully declined a similar invitation from the DuPage County Medical Society, citing the "spirit" of the Society's policy to hold the Interim Session outside the metropolitan Chicago area.

## COST EFFECTIVENESS

Noting that employees who are fully-informed about health insurance benefits are better

equipped to take full advantage of coverage, avoid misunderstandings and obtain the best possible medical care, the Board voted to:

- Urge health insurance companies to provide and aggressively market an employee communication service to covered employee groups, emphasizing limitations and options for services in an ambulatory setting.
- Encourage businesses and labor organizations to provide directly—or obtain from the health insurance intermediary—an employee communication service emphasizing limitations and optional coverage for services in an ambulatory setting . . . and continually remind employees of their benefits. ISMS also will seek assistance from the Health Insurance Association of America in identifying a company with whom a pilot program could be initiated.
- Suggest that physicians advise patients to communicate with their insurance carrier's contract representative, employer or union representative regarding any questions about insurance benefits. Where the physician has doubts about a patient's awareness or feels the insurance may not be adequate, he should encourage the patient to obtain complete information before proceeding with medical care.
- Direct the Task Force on Cost Effectiveness to develop—and publicize to the general public—a set of optimal health insurance features which would be cost effective, as well as beneficial, to the insured and his employer.

Many patients seek unnecessary hospitalization for tests or minor surgical procedures because: (1) Insurance benefits do not cover out-patient services; (2) Employers will not pay them for time absent to have tests or procedures performed unless they are hospitalized; and (3) Many plans provide sickness and accident coverage only after the eighth day. To resolve these problems and contain costs, ISMS will:

- Urge insurance plans to provide coverage to the same degree for all tests and procedures including those done outside the hospital.
- Encourage employers to provide employees time off with pay to take advantage of these outpatient services.
- Urge employers to design income benefits to encourage outpatient or ambulatory care as opposed to hospital care.

In implementing the above action, ISMS will publicize to employers and insurance carriers that Individual Practice Associations emphasize cost-effective ambulatory care.

In actions aimed at eliminating unnecessary short-term hospital stays and encouraging more realistic price competition between hospitals and physician offices, the Board voted to:

- Urge all parties involved in employee health benefit contracts to become knowledgeable with and utilize effective utilization review—both concurrent and, in special problem areas, focused review—through carriers, foundations and/or with hospitals.
- Support employee health benefit plan designs which would discourage additional payment for care rendered in a less appropriate setting, such as emergency room versus physician offices.

The Board also: (1) Urged the Commission to Rewrite the Public Aid Code to utilize the Statewide Health Coordinating Council and the Illinois Health Finance Authority in addressing public aid problems; and (2) Authorized the Task Force on Cost Effectiveness to work with representatives of labor and industry in studying changes in the tax laws which would encourage co-pay and deductible benefits.



## NEW HEALTH PRACTITIONERS

The Board adopted the following position statement concerning activities of so-called "physician extenders":

Physician extenders shall function only under the direction and supervision of a physician licensed to practice medicine in all its branches, which physician is responsible for the differential diagnosis, prescription of therapeutic or corrective measures, and delegation of appropriate tasks for the physician extender, and such physician extenders shall perform only those acts in the provision of health care services specifically allowed by appropriate licensure or registration acts.

ISMS will notify the Illinois Department of Registration and Education that proposed rules and regulations implementing the Physician's Assistants Act are acceptable, provided Rule V, Section 8 is amended to state that: "The Physician's Assistant may not *independently* refer to new modalities of therapy or obtain consultations."

## STATEWIDE PSRO COUNCIL

The Board endorsed creation of a Statewide PSRO Council—required under federal law—to coordinate PSRO activities and evaluate performance. The Council would consist of two physicians designated by ISMS, two physicians designated by the Illinois Hospital Association, one physician representative from each PSRO and four public representatives—at least two of whom must be nominated by the governor. PSROs have indicated creation of the Statewide Council would be in their best interests.

## SPECIAL PROGRAMS

Acting on requests concerning special programs, the Board voted to:

- Co-sponsor an Illinois Department of Public Health program Nov. 15 in Springfield designed to "sensitize" county health department nurses to the jail environment. The program was planned because many local health departments have been encouraged to offer their services to jails. Co-sponsorship does not involve a financial obligation. ISMS assisted in promotion and dissemination of materials, and provided a speaker to outline the Illinois Jail Health Program.
- Approve plans for a joint ISMS-Illinois CPA Society program on financial topics of interest to physicians and CPAs with medical clients. Scheduled for May 21, in the Chicago area, the program will include: Plenary Sessions—estate planning and professional corporations; Physician Workshops—Perks and investment planning; CPA Workshops—Medicaid billing/audits and what physicians need from accountants. Registration fee will be \$65, and income will be divided between ISMS and the CPA Society based upon a percentage of registrants from each organization.

## IDPA DRUG MANUAL

The following drugs were approved for inclusion in the IDPA Drug Manual: Ditropan, Dialose, Dialose Plus, Kasof, Levsin Preparations (1-hyposcymine sulfate), Cyclapen (Cyclacillin) Tablets and Suspension, Inderide, Anusol HC and Wyanoids HC.

## SEARCH COMMITTEE

A special committee was appointed to seek a successor to ISMS Executive Administrator Mr. Roger White, who plans to retire upon expiration of his contract on June 30, 1981. Named to the committee were: *Drs. Alfred Clementi*, Arlington Heights; *Robert Hartman*, Jacksonville; *Alfred Kiessel*, Decatur; *Clifton Reeder*, Park Ridge; *John Ring*, Mundelein; *P. John Seward*, Rockford; and *David Fox* and *Morris Friedell*, both of Chicago.

## APPOINTMENTS/NOMINATIONS

The following physicians were nominated for appointment to state commissions and committees:

- *Commission on Health Assistance Programs* (To study need for state catastrophic insurance plan)—*Drs. Louis Arp*, Moline; *Lorris Bowers*, Peoria; *Robert Hamilton*, Alton; *Robert Johnson*, Springfield; *P. John Seward*, Rockford; and *John Schweppe* and *Charles Beck*, both of Chicago.
- *Health Facilities Planning Board Advisory Committee* (To recommend standards and criteria for appropriateness review programs in institutions)—*Drs. B. Smith Hopkins*, Champaign, and *Harry Springer*, Chicago.
- *Board for Opinions on Professional Nursing*—*Drs. Morgan Meyer*, Lombard, and *Daniel Pachman*, Chicago.
- *Drivers License Medical Advisory Board*—*Dr. Arnaldo DeCarvalho*, Springfield.
- *Children's Vision Services Advisory Committee* (To advise IDPH on rules and regulations pertaining to the vision screening programs in schools)—*Drs. Samuel Schall*, Chicago; *Victor Feldman*, Champaign; and *Eugene Folk*, Chicago.
- *Children's Hearing Services Advisory Committee* (To advise IDPH on rules and regulations pertaining to hearing screening programs in schools)—*Drs. Horst Konrad*, Springfield; and *Lloyd Thompson*, East St. Louis.

In related action, the Board directed the Governmental Affairs Division to review the proliferation, composition, function and need for all state commissions and committees—presently constituted and proposed—to which ISMS nominates or will be asked to nominate physicians.

*Drs. Lee Gladstone*, Chicago, and *Thomas Kirts*, DeKalb, were appointed to the ISMS Panel for the Impaired Physician . . . *Dr. Robert Johnson*, Springfield, was appointed to the ISMS Committee on Constitution & ByLaws . . . *Dr. Kenneth Hurst*, Naperville, was appointed to the ISMS Governmental Affairs Council . . . and *Dr. Jerry Ingalls*, Paris, was named the ISMS representative to the 1980 AMA Conference on Rural Health.

Reappointed ISMS representatives to the Illinois Cooperative Health Data System Board of Directors were: *Drs. Alexander Goldstein*, Harrisburg; *Allan Goslin*, Streator; *Donald Hanscom*, Hinsdale; *Joseph O'Donnell*, Glen Ellyn; *Clifton Reeder*, Park Ridge; *Walter Stevenson*, Quincy; *Pen Williams*, Urbana; and *Audley Connor* and *Henrietta Herbolsheimer*, both of Chicago; and *Mr. Roger White*, ISMS executive administrator. In addition, *Mr. Don Kline*, executive vice president of the Mid-State Foundation for Medical Care, was appointed to represent the state's PSROs on the ICHDS Board, following a slot allocated to ISMS that was occupied by former ISMS legal counsel *Mr. Joel Edelman*.

The *Illinois Thoracic Surgical Society* was granted membership on the ISMS Council on Affiliate Societies as well as the privilege of the floor in the House of Delegates effective at the 1979 Interim Session.

The Board authorized continued operation of the ISMS Task Force on Professional Liability, but directed the Board chairman—in consultation with the Task Force chairman and ISMS Board of Directors—to reconsider its composition. ◀



# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

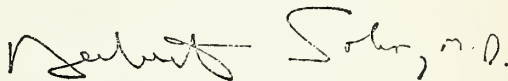
55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

Dear Friends

I thought this might be the appropriate forum to announce the 1979 membership figures for your Illinois Medical Political Action Committee. I am pleased to announce that in 1979, more of you were IMPAC members than ever -- over 11,000 members. This year, IMPAC has 5,709 physician members -- an increase of 271 new members over last year. This increase reflects a greater interest on your part. Each year more and more physicians and their spouses gather with IMPAC and accept their responsibility as active participants in molding our political lives.

Once again an overwhelming number of IMPAC memberships are \$45.00 family memberships -- this means that the Illinois medical community, both physicians and spouses, strongly supports medical political action via IMPAC.

Now we must look ahead to 1980. 1980 is an election year when demands on IMPAC are greater than ever. We can only face those demands with your support. Your 1980 ISMS dues includes a provision for contributing to IMPAC; please do so generously. If you've already remitted your dues without an IMPAC membership, please use the coupon below. Finally, if you weren't a member last year, start the decade off right -- join IMPAC. It's one investment that guarantees long term dividends.



Herbert Sohn, M.D.  
Chairman

### IMPAC Membership

(check one)

- ☐ Sustaining .....\$99  
☐ Family .....\$45  
☐ Regular .....\$25  
☐ Auxiliary .....\$20

Return to:

IMPAC  
55 E. Monroe Street  
Suite 3510  
Chicago, Illinois 60630

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

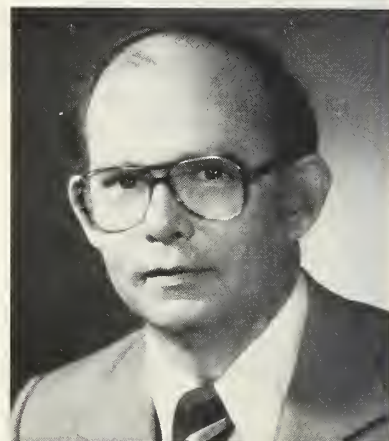
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# President's Page

*What man wants is simply independent choice, whatever that independence may cost and wherever it may lead.*

Dostoevsky



## A Voice In The Ethics Debate

By its very nature, the process of change produces anxiety. That is especially true when the subject of change is the Principles of Medical Ethics.

For the past several years, the AMA has been considering changes in the Principles. A special blue-ribbon committee has weighed the merits and drawbacks of change, and now has proposed specific modifications. Predictably, the committee's recommendations have spurred thoughtful comment as well as controversy.

Ethics are firmly embraced by each of us. The problem revolves around how we, as individual physicians, define and interpret their meaning. Ethics are much more than words on paper, and their demands surpass those of law. Any time we seek to change both the words and their interpreted meaning, conflict is assured.

The reasons advanced for changing the Principles are simplistically summarized in two arguments. One is that replacing archaic language with modern wording will allow more accurate interpretation in our changing world. The other is that change will avoid conflicts with government and the resultant myriad of lawsuits which threaten to decimate the financial base of organized medicine.

The ISMS House of Delegates recently acknowledged the need for appropriate modification of the Principles, provided those revisions do not compromise the historical goals and standards of the profession.

As the Society's policy-making body, the House routinely takes definitive action that affects Illinois medicine. However, your elected representatives were keenly aware of the significance for each physician of the proposed ethical code changes. That awareness prompted the House to urge each county medical society to poll its membership on the wording, content and advisability of the AMA Committee's recommendations. The poll will be conducted within the next few months . . . and final AMA action is slated for later this year.

The House action grants each ISMS member a direct voice in this debate. I urge each of you to commit yourselves to a thorough, objective analysis of the proposed changes. That analysis should include consideration of the long-term effects as well as the immediate impact.

By participating in the survey, you ensure that your views are considered. Failure to respond will jeopardize the effectiveness of "grass roots" participation in organized medicine. ◀

A handwritten signature in cursive script, reading "P. John Seward, M.D.".

P. John Seward, M.D., President



# Doctor's News

**IDPH TO PROVIDE INFLUENZA VACCINE**—The ISMS Board of Trustees recently voted to endorse IDPH immunization program for influenza, while informing IDPH that the decision of whether or not to immunize a patient must rest with the individual's physician, who knows the patient best, and urging IDPH to clarify its instructions to physicians who order the vaccine.

IDPH is urging use of the influenza vaccine, which it will provide at no cost to local health departments for use in public clinics and long term care facilities. It is intended for use by persons age 65 or older, and persons with chronic disease. The vaccine is intended to combat virus strains A/Brazil, A/Texas and B/Hong Kong.

**NEGOTIATION SKILLS SEMINARS ANNOUNCED**—The American Medical Association will again sponsor physician seminars in negotiation skills in 1980. A special one-day program will be held February 20, immediately before the National Leadership Conference scheduled February 21-24, in Chicago. The Chicago Medical Society will co-sponsor a seminar March 30, during their Midwest Clinical Conference. Programs are eligible for Category 1 CME credit on an hour-for-hour basis. Further information about the seminars, and other negotiating seminars sponsored outside Illinois, may be obtained by writing the AMA Department of Negotiations, 535 N. Dearborn St., Chicago, IL. 60610.

**1980 TRAVEL SCHEDULE ANNOUNCED**—The 1980 travel schedule for ISMS members and their families will initiate with an Around the World Adventure on January 25 to return February 28. Further trips scheduled include: February 25-March 13, Australia/New Zealand, Fiji; April 26-May 4, Monte Carlo; June 8-June 21, Spain and Portugal and July 25-August 6, Danube River Cruise (Istanbul to Vienna). A Far East trip is scheduled for late September, to include Hong Kong, Singapore and Bangkok.

Further information may be obtained by contacting the ISMS offices, 55 E. Monroe, Suite 3510, Chicago 60603; (312) 782-1654.

**1980 CENSUS APPROACHES**—On March 28, 1980, every home in the United States will receive a Census questionnaire. Respondents will be asked to complete this and return it, usually by mail, to the U.S. Department of Commerce Census Bureau. The Constitutional purpose of the Census is to determine fair reapportionment among the States of seats in the U.S. House of Representatives. More recently, the Census information has also been used to redistrict representation in some state legislatures and to gather socioeconomic data.

The law under which the census is taken protects confidentiality of responses. None but sworn census takers will have access to identifiable data for the next 72 years. The law provides that information may be used only for statistical purposes and cannot be published or released in any manner which could permit identification of persons or corporate entities.

Two census forms will be circulated—80% of household will receive a short form with 19 questions, and the remaining population will be required to answer 46 additional questions. This year's census will consider a few new items, particularly related to racial and ethnic origin, energy use and journey-to-work patterns.

**MALARIA CONTINUES UPSWING**—The United States Center for Disease Control has reported that the number of infected U.S. civilians in 1978 was 616, a 67% increase over 1977 and quadruple the number of reported malaria cases in 1970. CDC has stated that the total reflects an international resurgence of malaria. This has affected the U.S. because of increased travel to malarious areas, and increasing immigrants from such countries. The greatest number of cases were traced to the Indian subcontinent. Seasonal distribution again followed the 1977 pattern, showing a peak in late spring and summer. An increase in imported malaria cases has also been reported in Western Europe, according to the CDC.

**PHYSICIANS IN THE NEWS**—Seventeen Illinois physicians have been named fellows of the American College of Chest Physicians. They include **Donald W. Aaronson, M.D.**, Niles, **Asuncion C. Berroya, M.D.**, Oak Brook, **Robert N. Gamble, M.D.**, Evanston, **Sukhjit S. Gill, M.D.**, Oak Brook, **Raymond F. Hillson, M.D.**, Moline, **Dennis L. Karsh, M.D.**, Glen Ellyn, **Pradeep S. Kulkarni, M.D.**, Springfield, **Ahamed V. P. Kutty, M.D.**, Bourbonnais and **Abdul Razzaq, M.D.**, Granite City. Chicago physicians newly named as fellows are **Anthony J. Balisteri, M.D.**, **Julius M. Gardin, M.D.**, **Lauren D. Holinger, M.D.**, **Nelson Kanter, M.D.**, **Mushtaq A. Khan, M.D.**, **Ramesh N. Patel, M.D.**, **John H. Sanders, Jr., M.D.**, and **Peter Werner, M.D.**

**Ismail E. Atcha, M.D.**, Chicago, was recently elected a fellow of the American College of Physicians. . . . **Herschel Browns, M.D.**, Chicago, ISMS president-elect, was recently elected to the Board of Directors for the Ravenswood Hospital Medical Center.

**LICENSE RENEWAL REMINDER**—All Illinois medical licenses will be subject to renewal by the Illinois Department of Registration and Education as of July 1, 1980. Forms for license renewal will be mailed next spring.

Illinois law requires that 100 hours of continuing medical education (CME) credit be earned during a pre-license renewal period. Statutes stipulate that at least 50 of the 100 hours must be Category 1; the balance of hours may be accredited for Category 2 CME. Credit must be earned by each physician during the two year period April 1, 1978 through March 31, 1980. Of the 50 hours Category 1 credit, a minimum 20 must be part of an approved, formal educational program as specified in the Act. The balance may fall into the realm of approved teaching or medical care audit activities.

**ISMS ANNUAL MEETING RESOLUTION DEADLINES**—The 1980 Annual Meeting of the ISMS House of Delegates will be held April 13-16, 1980, at the Chicago Pick Congress Hotel.

Resolutions submitted for consideration should be addressed to the ISMS offices. Those resolutions received by February 10, 1980, will be published, by title and number only, in the *IMJ*. The final deadline for receipt of resolutions is March 16, 1980. Resolutions received after that date will be admitted only upon special consideration by the ISMS Committee on Rules and Order of Business.

**MECO PROJECT PARTICIPANTS ANNOUNCED**—The 1980 Illinois MECO Project, co-sponsored by the ISMS-SBS, Illinois Hospital Association and Illinois Academy of Family Practice, seeks participants for their 1980 programs. The MECO project provides ten week orientation programs for medical students. Hospitals interested in joining the program should contact ISMS headquarters.



## Rheumatology

For: MD's. Symposium, March 22, 1:00 p.m., Lawrenceville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Respiratory Disease

For: MD's. Symposium, March 26, 6:00 p.m., Granite City. Sponsor: SIU School of Medicine, 801 N. Rutledge, P.O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Neurology

### Scientific Aspects of Neurology

For: Neurologists, Psychiatrists, Neurosurgeons. Workshop, March, 19-22, Continental Plaza Hotel, Chicago. Sponsor: University Office of Continuing Education, 600 S. Paulina, Chicago 60612. Cosponsor: Rush-Pres.-St. Luke's Medical Center. Reg. deadline: March 12. Fee: \$300. Credit: AMA Category 1, 28 1/2 hours. Contact: Joseph Voal. Phone: 312/942-7119.

## Pediatrics

### Downstate Illinois Pediatric Society Meeting

For: MD's. Symposium, March 29-30, Springfield. Sponsor: Downstate Illinois Pediatric Society, 320 E. Armstrong, Peoria 61603. Cosponsor: SIU School of Medicine. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 7 hours. Contact: Thomas Smith. Phone: 309/672-6341.

## Psychiatry

### Specialty Review in Psychiatry

For: Psychiatrists, Neurologists. Lecture, March 10-14, Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 100. Credit: AMA Category 1, 41 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Psychiatry & Law

### Civil Law and the Psychiatrist

For: Psychiatrists, Attorneys. Workshop, March 14-15, Continental Plaza Hotel, Chicago. Sponsor: Dept. of Psychiatry and Law Department of Psychiatry, University Office of Continuing Education, 600 S. Paulina, Chicago 60612. Cosponsor: Rush-Pres.-St. Luke's Medical Center. Reg. deadline: March 7. Fee: \$150. Reg. limit: 200. Credit: AMA Category 1, 12 hours. Contact: Joseph Voal. Phone: 312/942-7119.

## Pulmonary Medicine

### Pulmonary Board Review Course

For: MD's. Course, March 31-Apr. 4, Conrad Hilton Hotel, Chicago. Speaker: Reuben Cherniack, MD. Sponsor: American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. Contact: Mary Ellen Zielinski. Phone: 312/698-2200.

## Advances in Surgery

For: General & Specializing Surgeons. Lecture, March 24 (5 days), Chicago. Speaker: Robert Baker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, M.D. Phone: 312/733-2800.

## Surgery

## Cardiac Rehabilitation

### Total Cardiac Rehabilitation Workshop

For: MD's, RN's, Physical Therapists. Workshop, Week 1, April 7-11 (lecture), Week 2, April 14-18 Optional (staff participation), La Crosse, WI. Sponsor: La Crosse Exercise Program—Workshop Unit, Mitchell Hall, University of WI, La Crosse 54601. Fee: \$350, week 1; \$200, week 2. Reg. limit: 50. Credit: various. Contact: Philip Wilson. Phone: 608/785-8686.

## Family Medicine

### Annual Postgraduate Seminar

For: FP's. Seminar, April 18-22, Holiday Inn Mart Plaza, Chicago. Sponsor: Illinois Academy of Family Physicians, 1200 Harger Rd., Suite 405, Oak Brook 60051. Fee: members, n/a; non-member, \$25. Credit: AMA Category 1; AAFP Prescribed. Contact: H. Marchmont-Robinson, MD. Phone: 312/325-8502.

## Immunohematology

### Blood Transfusions, Its Hazards and Liabilities

For: MD's, DO's, RN's, MT's. Seminar, April 17, 7:00 p.m., Moline Public Hospital, Moline. Speaker: Joseph Bove, MD. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust St., Davenport, IA 52803. Reg. limit: 200. Fee: \$15. Aux. Med., \$4. Credit: AMA Category 1, 2 hours. Contact: Patricia Harrod. Phone: 319/359-5401.

## Internal & Pulmonary Medicine

### Specialty Review Course in Pulmonary Disease

For: Pulmonary Specialists. Lecture, April 28 (5 days), Chicago. Speaker: John Sharp, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: \$150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Medicine

### Cardiovascular

For: MD's. Symposium, April 2, 8:00 a.m., Chester. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Fifth Annual Postgraduate Course on

#### Gastroenterology

For: MD's. Course, April 4, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Fee: yes. Reg. limit: none. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Burn Management Symposium

For: MD's. Symposium, April 9, 8:00 a.m., Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 8 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Orthopaedic Problems

For: MD's. Symposium, April 17, 1:00 p.m., Litchfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Diabetes and Rheumatology

For: MD's. Symposium, April 23, 1:00 p.m., Jerseyville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### State & National Board Review, Basic

For: MD's. Lecture, April 7 (6 1/2 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$325. Reg. limit: 150. Credit: AMA Category 1, 58 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Medicine

### State & National Board Review, Clinical

For: MD's. Lecture, April 14 (6 days), Chicago. Speaker: Sheldon Waldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$300. Reg. limit: 150. Credit: AMA Category 1, 53 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Neurosurgery

### Strokes or CVA

For: GP's, full time specialty. Lecture, April 9, 9:30 a.m., Chicago. Speaker: Javad Hakmatpanah, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 6 hours. AAFP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

## Ob-Gyn

### Specialty Review in Ob-Gyn

For: Obstetricians, Gynecologists. Lecture, April 21 (6 days), Chicago. Speaker: John Isaacs, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 125. Credit: AMA Category 1, 44 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Pediatrics

### The Hyperactive Child

For: MD's. Symposium, April 11, 10:45 a.m., Oak Park. Speaker: Paul Dunn, MD. Sponsor: Oak Park Hospital, 520 S. Maple, Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## Pediatrics

### Hypertension in Children

For: MD's. Symposium, April 18, 10:45 a.m., Oak Park. Speaker: Robert Miller, MD. Sponsor: Oak Park Hospital, 520 S. Maple, Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## Pediatrics

### Urinary Tract Infections in Children

For: MD's. Symposium, April 25, 10:45 a.m., Oak Park. Speaker: Mark Lakin, MD. Sponsor: Oak Park Hospital, 520 S. Maple, Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## Psychiatry

### Francis J. Gerty Lecture Series

For: MD's, Therapists. Lecture, April 16, 1:00 p.m. Forest Park. Speaker: Carl Whitaker, MD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

## Radiology/Orthopedics

### Seminar/Workshop on Arthrography and Skeletal Trauma

For: Radiologists, Orthopedic Surgeons, GP's, FP's, Emergency Room Physicians. Lecture/workshops, April 28-30, Sheraton Inn, Madison, WI. Sponsor: University of WI—Extension, Dept. of CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. Cosponsor: University of WI—Madison, School of Medicine, Dept. of Radiology. Fee \$250, seminars & workshops; \$200, seminars only. Credit: AMA Category 1, 21 hours; ACR, applied for. Contact: Sarah Aslakson. Phone: 608/263-2856.

## Urology

### Specialty Review Course in Urology

For: Urologists. Lecture, April 7 (5 days), Chicago. Speaker: Irving Bush, MD; Thomas John, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Urology

### Bladder Cancer

For: Urologists. Seminar, April 10-12, Continental Plaza Hotel, Chicago. Sponsor: American Urological Association, Inc., Office of Education, P. O. Box 1129, Aspen, Colorado 81611. Fee: \$250. Reg. limit: 250. Credit: AMA Category 1, 16 hours. Contact: Joan Greiner. Phone: 303/925-2012.

# April

## RECENT CME ACCREDITATIONS

The ISMS Committee on CME Accreditation has approved the CME programs of the following institutions:

Jackson Park Hospital, Chicago  
Lake Forest Hospital  
The Methodist Medical Center of Illinois, Peoria  
St. Anthony Hospital Medical Center, Rockford  
St. Elizabeth Hospital, Granite City  
St. Mary of Nazareth Hospital, Chicago

# Illinois Society, American Association of Medical Assistants

## The Human Factor in Medical Assisting

BY RUBY JACKSON, CMA, PAST PRESIDENT, AAMA, ILLINOIS SOCIETY

Psychologists say that the most productive working condition is that which precludes danger of interruption. There are exceptions to every rule, and the exception to this one is any medical office on any given day. It is occasionally possible to work behind a closed door for a short period of time but this usually produces a backlog of phone calls which must be returned.

In the medical office there are no "DO NOT DISTURB" signs, regardless how full the schedule. Most of the time, it is the medical assistant who answers the phone, collects the fees, send the bills, and may be with patients for longer periods of time than the physician.

The medical assistant can help her employer by realizing that people react differently under stress of illness and must develop a rapport with them. The "tender-loving-care technique" is not to be overlooked, but there are other ways to indicate understanding and an interest in the patient's problem and feelings.

AAMA, Illinois Society, believes that the qualifications for a medical assistant are the same as for other positions: intelligence, dependability, accuracy, tact, willingness to learn, adaptability, and an interest in people (not necessarily in that

order). Accuracy is important in any office or business but doubly so in the medical office where human life and health are at stake.

Perfection is probably unattainable, but with constant alertness and effort, accuracy can be improved and brought to a satisfactory level. Perfection should always be striven for, so high levels of accurate performance may be achieved and maintained.

AAMA, Illinois Society, offers seminars on human relations to help YOUR medical assistant become proficient in projecting the "human factor" in YOUR office.

As we enter into the New Year, AAMA, Illinois Society, would like to express sincere appreciation to the Illinois State Medical Society for your past support and encouragement. We resolve for 1980 to strive to warrant your continued interest, support, and encouragement.

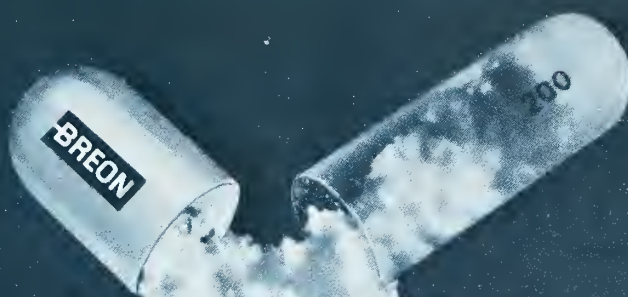
For information regarding AAMA, Illinois Society, contact Cissy A. Egly, CMA, President, 1413 Midland Manor, Joliet, IL 60436, or Luella V. Mitchell, Chairman, Public Relations Committee, 7920 Eberhart Avenue, Chicago, IL 60619. ◀

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## *AAMA, Illinois Society, Extends Greetings For a Healthy, Happy, Prosperous 1980*



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- Bioavailability equal to an elixir<sup>1</sup>
- Achieves blood levels rapidly<sup>1</sup>

<sup>1</sup> Tinkelman, D.G., Carroll, M.S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. *Medical Challenge* 10: 24-26, 1978.

**BREON**

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## BRONKODYL<sup>®</sup>

BRAND OF THEOPHYLLINE, USP (ANHYDROUS)

**BRIEF SUMMARY:** Before prescribing, please consult complete prescribing information, a summary of which follows:

**INDICATIONS:** For relief and/or prevention of bronchospasm associated with bronchial asthma, chronic bronchitis and emphysema.

**CONTRAINDICATIONS:** Hypersensitivity to any of its components.

**WARNINGS:** Theophylline should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

Status asthmaticus is a medical emergency. Addition of corticosteroids and other medications to bronchodilator therapy may be required.

Serum theophylline levels should be monitored at appropriate intervals for dosage adjustment. High serum levels of theophylline and resultant toxicity may occur with conventional doses in patients with decreased theophylline clearance as found with cardiac failure, liver disease, chronic obstructive pulmonary disease, and in geriatric patients.

Early signs of theophylline toxicity, such as nausea and restlessness may not occur prior to convulsions or ventricular arrhythmias. Pre-existing

arrhythmias may be worsened by theophylline.

**Usage in Pregnancy:** Theophylline safety in pregnancy has not been established. Use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

**PRECAUTIONS:** Smokers may require larger doses of theophylline because of a shorter half-life in these patients.

Theophylline should not be administered concurrently with other xanthines

Caution should be observed in patients with cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, peptic ulcer, and in the elderly and neonates. Patients with congestive heart failure in particular may have markedly prolonged serum half-lives of theophylline.

**ADVERSE REACTIONS:** Most adverse reactions to theophylline are seen with serum levels exceeding the therapeutic range. **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea. **CNS:** headache, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions. **Cardiovascular:** palpitations, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias which may be life-threatening. **Respiratory:** tachypnea. **Renal:** diuresis, albuminuria. **Other:** hyperglycemia, inappropriate ADH

secretion.

**Drug Interactions:** Toxic synergism with ephedrine and other sympathomimetic bronchodilators may occur.

### OVERDOSAGE Treatment:

- If potential oral overdose is established and seizure has not occurred: 1) Induce vomiting. 2) Administer a cathartic. 3) Administer activated charcoal.
- If patient is having a seizure: 1) Establish an airway. 2) Administer O<sub>2</sub>. 3) Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg. 4) Monitor vital signs, maintain blood pressure and provide adequate hydration.
- Post-seizure coma: 1) Maintain airway and oxygenation. 2) If a result of oral medication, follow above recommendations to prevent absorption of drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube. 3) Continue to provide full supportive care and, adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapidly so as to not warrant consideration of dialysis.

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Code 1833

# Pulse of the ISMS Auxiliary

## Preventive Medicine: Out of Focus

BY MRS. R. S. HOOVER, PRESIDENT, ISMSA

In tune with auxiliaries all over the United States, the focus for the Illinois Auxiliary this year is preventive medicine and promoting healthful lifestyles. I was interested, amazed and shocked to hear recently that the health industry is being blamed for a lack of preventive medicine programs and health education in the United States today.

At the Blue Cross/Blue Shield-sponsored conference on National Health Insurance, speakers unanimously agreed only on the need for preventive medical programs. Preventive medicine was cited as a *reason* for implementing comprehensive health insurance—as if instantly, with a national health program, people would automatically eat properly, stop smoking, curtail alcohol consumption, sleep well, use seat belts, drive carefully and see the company doctor once a year! Nonsense. Business leaders, legislators, labor representatives, health industry experts, economists, and consumer representatives seemed to feel that prevention was the area that needed attention—and where we, as leaders of the health industry, may be falling down.

In response, I thought, where have all these people been? It seems to me that there are excellent programs abounding. It's just that the public isn't taking the medicines. Hospitals are into the act with seminars, clinics and newsletters. The Public Health Service is spending millions on health projects, including \$22 million this year on alcoholism projects alone. How much has the anti-smoking campaign cost? Each major disease has a series of prevention do's and don'ts publicized by the government and/or private volunteer health agencies. Look at the work that the American Cancer Society or the American Heart Association has done, to name but two examples. Health Education is in the schools by *law*. There is a proliferation of "how to" books and periodicals put out by private individuals. Who could have predicted the unbelievable interest in diet books and fitness/exercise manuals that we have now?

Auxiliaries have been leaders in their communities by sponsoring programs on CPR, nutrition, alcohol, drug, child and spouse abuse, water, auto and bicycle safety and screenings for vision,

hearing and scoliosis. A very successful immunization program brought a commendation to the AMA Auxiliary from Health Education and Welfare Secretary Patricia Harris! No preventive programs? Hardly! It seems to be a case of "You can lead a horse to water, but . . ."

The Illinois Auxiliary Board is currently investigating preventive medicine and public relations projects including a possible media presentation drawing attention to auxiliary preventive medicine activities. The American Medical Associations Auxiliary *Shape Up For Life* program is one example. It is a reminder to concentrate on one's diet, proper nutrition and physical fitness/exercise.

I suppose that the cost of health care is a major reason for the new emphasis on preventive programs. It seems that health plans such as President Carter's, Senator Kennedy's and Senator Long's have been overshadowed by our economic and foreign policy problems, and are not likely to be passed in the foreseeable future. Perhaps national health insurance is indeed "an idea whose time has passed," as stated by Alan Greenspan, former chairman of the President's Council of Economic Advisors. Most Americans have found insurers, employers, Medicare, or Medicaid to pay their medical bills. This, coupled with increasing distrust of government ability to do things efficiently and economically may explain declining demand for national health insurance. Perhaps the American public is learning that there is no such thing as free medical care—that we all pay, with higher taxes, higher costs of consumer goods, rising social security deductions, and inflated dollars—and that government would only compound the problem. Will cost factors increase preventive programs? Possibly—at least we are more conscious of what we are or are not doing to keep ourselves healthy.

All this becomes academic, however, with the thought of a holocaust, pestilence, or invasion of dread disease. Then we need our doctors as healers—men in the healing business who treat disease, dysfunction and disabilities. So, I think that we have to put preventive medicine in perspective—important, yes—the bottom line, *no*. ◀



**Blue Cross®  
Blue Shield®**



# REPORT

## FOR *Illinois Physicians*

### Service Report Filing Procedures For Employees Of Jewel Company Groups

Jewel Company is comprised of 30 payroll and membership groups. The groups are covered by the Chicago-based Blue Cross and Blue Shield Plans. Their Blue Cross and Blue Shield Identification cards will aid us in processing Blue Cross and Blue Shield claims under an improved system.

The system being used requires additional information on the Blue Shield Service Report form. This new information will permit us to identify promptly all claims and physician inquiries for covered services or services furnished.

When a Blue Shield member presents one of the Jewel group ID cards—such as the Osco Drug card shown in the sample below—the member's signature should be on the face of the card under the line "Protection Provided Under the Package Plan of Jewel Companies, Inc." The reverse side of the card shows the

employee (subscriber's) name, Group No. 80055/100, and employee's Social Security number.

The three digit subscriber number following the Group Number must follow in sequence in the Physician's Service Report form to prevent payment delays. (See reduced sample portion below of the present Blue Shield service report). There is adequate space on the Group Number and Member ID Number line for this information.

**PLEASE DO NOT USE THE PATIENT'S SOCIAL SECURITY NUMBER IN THIS SPACE UNLESS THE EMPLOYEE IS THE PATIENT RECEIVING SERVICES. YOU MUST ALWAYS USE THE EMPLOYEES SOCIAL SECURITY NUMBER.**

A complete list of Jewel's membership groups and their Group Numbers follows on the reverse side.

 <b>Blue Cross Blue Shield</b>  <b>OSCO Drug</b>	Protection Provided Under the Package Plan of JEWEL COMPANIES, INC.
	<i>John Doe</i> MEMBER'S SIGNATURE
	<small>The member named on the reverse side of this card and eligible members of his/her family are, while currently enrolled, entitled to benefits. To verify coverage and extent of benefits... PLEASE SEE REVERSE SIDE</small>
	<i>Amster Hickman</i> President Blue Cross & Blue Shield

Blue Cross Blue Shield	Health Care Service Corporation (a Blue Cross and Blue Shield Plan) 233 North Michigan Avenue, Chicago, Illinois 60601
NAME JOHN DOE	
GROUP NUMBER AND MEMBER I.D. NUMBER 80055/100 123-45-6789	
ABOVE NUMBER MUST APPEAR ON ALL CLAIMS AND INQUIRIES	
<small>TO HOSPITALS—Participating hospitals of any Blue Cross Plan should follow regular procedure to report admissions. Other hospitals telegraph Blue Cross-FAX-GRK-Chicago.</small> <small>TO PHYSICIANS—Upon completion of Physician's Service Report, this Blue Shield Plan pays physicians for certain professional services rendered to members. Mail report to address above.</small>	
FORM EB-670 HCSC 9-76	

**Blue Cross  
Blue Shield**



### PHYSICIAN'S SERVICE REPORT

233 North Michigan Avenue  
Chicago, Illinois 60601  
312/861-4200

Group and Member ID Number 80055/100 123-45-6789		FOR RECIPROCITY USE ONLY		Patient Number		
Patient's Last Name Doe	First Name John			Patient's Sex M	Patient's Age 29	Patient's Birth Date 1-3-51
Member's Last Name Doe	First Name John	Member's Address 1974 Oakwood Court	Street	City Chicago	State Ill.	Zip 60646
Patient's Relationship to Member 1—Self 2—Spouse 3—Dependent <input type="checkbox"/>	Member's Sex	Member's Employer Name	If Accident/Emergency Date: Time:			

(This report is a service to the physicians of Illinois)

# JEWEL COMPANY PACKAGE PLAN GROUPS & IDENTIFICATION NUMBERS

<i>Name of Jewel Company or Payroll Group</i>	<i>Group Number</i>	
	<i>Non-Medicare</i>	<i>Medicare</i>
<i>Central Management Payroll</i>		
Direct Marketing Division	80063/100-	
Jewel Food Stores	80063/110-	
Corporate	80063/120-	
Eisner Food Stores	80063/130-	
Oscos Drug, Inc.	80063/150-	
Jewel Egg Farms	80063/160-	
White Hen Pantry	80063/170-	
Buttrey	80060/100-	
Mass Feeding	80063/200-	
Jewel T Discount Grocery	80063/180-	
<i>Hospital-Medical Plan For Retired</i>		
Direct Marketing Division	80073/100-	80073/101-
Jewel Food Stores	80073/110-	80073/111-
Corporate	80073/120-	80073/121-
Eisner Food Stores	80073/130-	80073/131-
Oscos Drug, Inc.	80073/150-	80073/151-
Jewel Egg Farms	80073/160-	80073/161-
White Hen Pantry	80073/170-	80073/171-
Buttrey	80073/200-	80073/201-
Mass Feeding	80073/210-	80073/211-
Jewel T Discount Grocery	80073/180-	80073/181-
<i>Company Payrolls</i>		
Jewel Food Stores	80008/100-	
Jewel Egg Farms	80072/100-	
Oscos Drug, Inc.	80055/100-	
Eisner Food Stores	80056/100-	
Direct Marketing Division	80057/100-	
Corporate	80058/100-	
White Hen Pantry	80059/100-	
Buttrey Food Stores	80060/100-	
Mass Feeding (Staff)	80074/100-	
Jewel T Discount Grocery	80092/100-	

## How to Request Physician's Service Report Forms

Because Blue Shield wants to comply with requests from physicians for new supplies of the Blue Shield Physician's Service Report forms as soon as they are received, a procedure has been developed that will be helpful in expediting such requests:

(1) in placing your order for new Physician's Service Report forms, please use the color-coded insert having the name, address and physician's code number in it for identification. The insert is enclosed with every

supply of Physician's Service Report forms and will expedite reordering;

(2) If you do not have an insert, please use your office letterhead or billing statement with the order, showing name, address of the physician and his identifying code number if available. Send the request to the Blue Shield office to the attention of the Physicians' Code Section.

(3) Please do not use a copy of the Physician's Service Report form as an order form.





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(USPS 258-160)

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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

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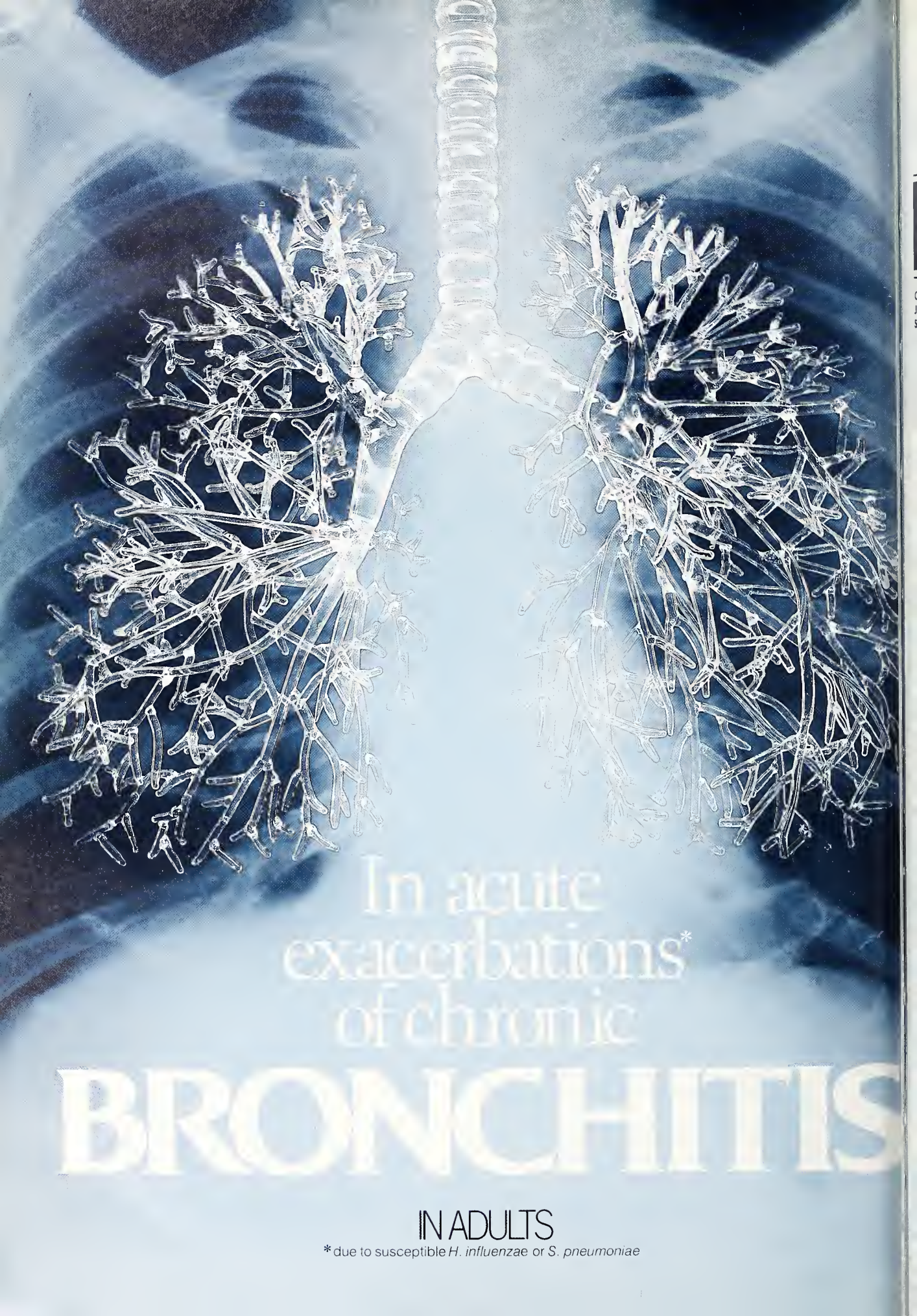
It is impossible to travel about the State of Illinois and not hear criticisms of medical practice today. Topics of concern range from the activities of the A.M.A. to governmental involvement in health care and planning, malpractice insurance, reimbursement policies and many others.

Why don't we put these concerns to use by sharing them with other Illinois physicians? We can accomplish this by writing letters to the editor of the *Illinois Medical Journal*.

A letter to the editor expressing your views, pro or con, would open a forum for all of us to communicate. If you have a pet project or a pet peeve, your letter might stimulate others to join you in a mutual activity for the benefit of all.

Let us have your letters to the editor. We welcome them.

Eli L. Borkon, M.D., F.A.C.P.  
Member, *IMJ* Editorial Board



In acute  
exacerbations\*  
of chronic

# BRONCHITIS

IN ADULTS

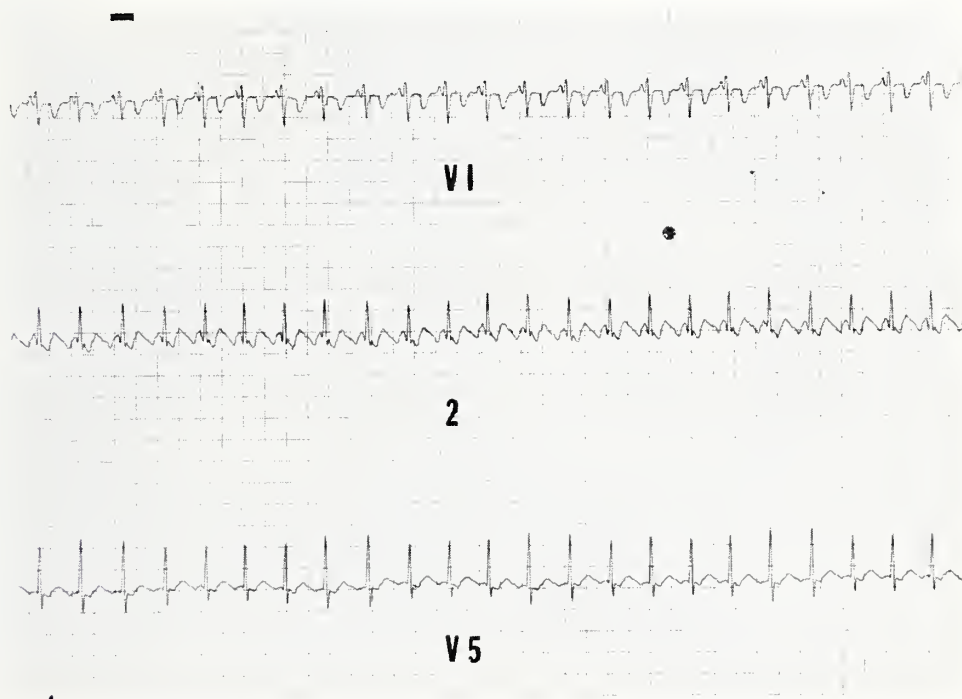
\* due to susceptible *H. influenzae* or *S. pneumoniae*



# EKG of the Month

Contributing Editors: Jahn F. Maran, M.S., M.D., David J. Hole, M.D., Patrick J. Scanlan, M.D., Sarah A. Jahnsan, M.D., Jahn R. Tabin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a sixty-four year old man with a long history of rheumatoid arthritis. He developed a gradually worsening dyspnea and presented to the emergency room with recent onset palpitations. Physical examination demonstrated cyanosis, a respiratory rate of 28/minute, rales in both bases of the lungs, and a tachycardia of 150 beats/minute. Pulmonary function studies, performed two years earlier, showed a forced expiratory volume at one second of 40% of normal both before and after isoproterenol. Selected blood chemistries at this time were  $PO_2=44$ mm Hg,  $PCO_2=68$ mm Hg,  $BUN=50$ mg%, and normal electrolytes. The attached simultaneous leads  $V_1$ , 2, and  $V_5$  rhythm strip was recorded.*



## Questions:

### 1. The simultaneous ECG rhythm strip shows:

- A. Atrial flutter with 2:1 atrioventricular (AV) block.
- B. Atrial tachycardia with 2:1 AV block.
- C. Atrial fibrillation with a rapid ventricular response.
- D. Atrial arrhythmia with a Wenckebach AV block.

E. None of the above.

### 2. Which of the following are generally accepted methods of treatment:

- A. Use of quinidine.
- B. Use of digitalis.
- C. Use of direct current cardioversion.
- D. Use of overdrive atrial pacing.
- E. All of the above.

(Continued on page 113)

# ANUSOL-HC

SUPPOSITORIES/CREAM WITH HYDROCORTISONE ACETATE

#1 prescribed hemorrhoidal product

IT WAS  
NUMBER ONE  
IN 1959

AND IT STILL IS...

The professional source of  
modern anorectal comfort

## ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories

## ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

**Caution:** Federal law prohibits dispensing without prescription.

**Description:** Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

**Indications:** Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

**Contraindications:** Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

**Warnings:** The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

**Precautions:** Symptomatic relief should not delay definitive diagnosis or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

**Dosage and Administration:** Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

**Anusol-HC Cream — Adults:** After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

**NOTE:** If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

**How Supplied:** Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

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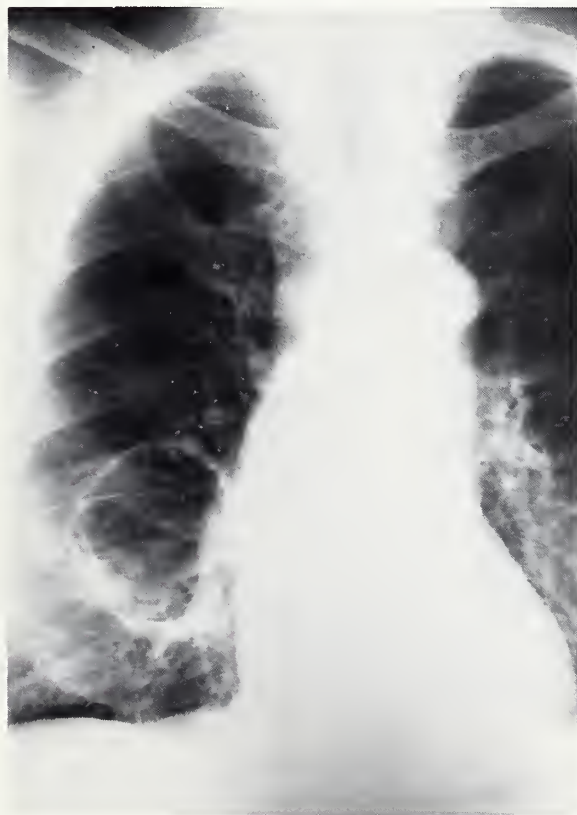


# The Viewbox

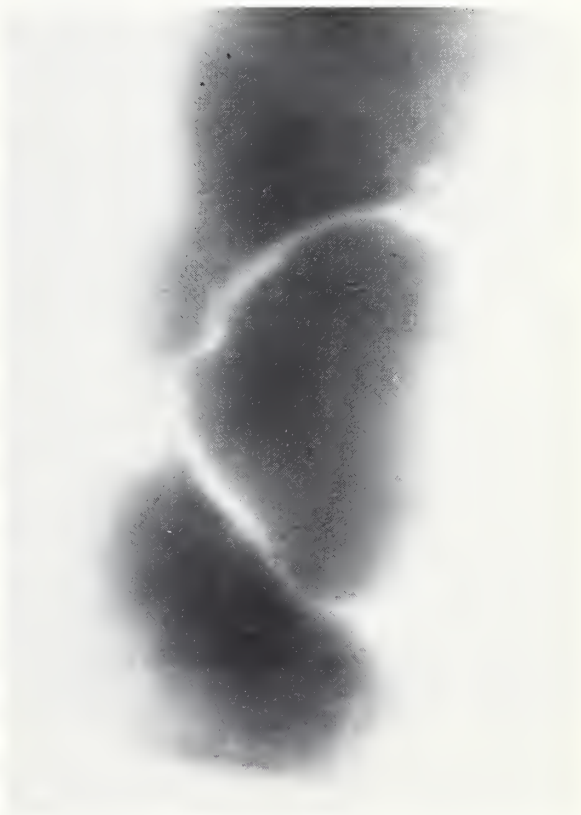
Contributing Editor Leon Love, M.D., chairman, Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was submitted by Terrence Demos, M.D., associate professor of radiology, Loyola University Medical Center, Maywood.*

*This 64-year-old man has had a productive cough and hemoptysis for the last three months.*



**Figure 1**  
PA Chest



**Figure 2**  
Laminogram of Right Lower Lobe

## What's Your Diagnosis?:

1. Wegner's Granulomatosis
2. Atypical Tuberculosis
3. Coccidioidomycosis
4. Cavitory Neoplasm
5. Infected Bulla

*(Continued on page 101)*

# Pulse of the ISMS Auxiliary

## *Have A Heart: You Too Can Be A Life Saver*

BY MRS. R. SAMUEL HOOVER, ISMSA PRESIDENT

"One, two, three, four—bend, stretch, touch the floor." The music blared, the instructor barked commands. Suddenly the 9:00 am exercise class came to a screeching halt. One of the ladies was on the floor! Not moving! Quickly another member of the class ran over to the inert figure. She shouted, "Are you all right?" No answer. She carefully rolled her friend over and checked for breathing, opened her airway and began mouth to mouth rescue breathing. Still no breathing or carotid pulse! Another member of the class quickly called the local emergency number—ambulance and paramedics were on their way. Immediately, the CPR-trained friend began external cardiac compression and continued the CPR until the advanced life support team arrived.

Yes, it happened to a doctor's wife—and yes, her friend had completed the CPR class only the day before the episode—and yes, both are doing well—and yes, every citizen should have CPR training. The American Heart Association reports that heart attacks cause over 650,000 deaths per year, and 350,000 people die of heart attack before they reach the hospital. Basic CPR knowledge and training may save some of these lives.

Many of our auxiliaries are involved with CPR training programs. Our newest auxiliary, Coles-Cumberland County, had a CPR training session as one of their first meetings. Auxiliaries have been particularly active in Will-Grundy and Peoria Counties, the "home bases" of our State Health Education chairmen. In a program initiated by 1978-1979 Health Education chairman Ann Arida, CPR education will become part of every health class in our high schools. In the Joliet program, after two hours of classroom instruction, students will be able to take two additional hours of training by Illinois Heart Association volunteers and receive CPR certification.

Ann Arida has been involved with CPR since she and her two children became certified as instructors and taught classes together. She currently serves as Will Grundy county auxiliary CPR chairman, Will Grundy CPR chairperson for the Illinois Heart Association and second vice president for the State Auxiliary.

The goal of the Illinois Auxiliary's 1979-1980 Health Education chairman, JoAnne Richardson of Peoria, and the Health Projects Committee, is that every high school graduate in Illinois will have training in CPR. JoAnne has been urging auxiliaries to continue and to expand the program. Many schools in our state, including schools in Will, Winnebago, Peoria, Lake and Vermilion counties, already teach CPR, and hopefully others will follow suit. JoAnne Richardson is a certified CPR instructor and chairman of the Illinois State Medical Auxiliary Health Education Committee.

If your auxiliary has not taken advantage of a class given by the Illinois Heart Association, please put it on your program agenda. After taking the CPR class, some members may want to take the CPR instructor course. Check with your heart association; they will be able to tell you when an instructor's course will be given. In some areas, the instructor's course is given at a local college, with college credit granted at successful completion. The Illinois Heart Association also has a film, *One Heart, One Life*, which is excellent and could be shown at auxiliary meetings, high schools or public gatherings. It is geared to the CPR training of high school students. Check with your school administration as to whether CPR has been added to the health education curriculum. This could be a great place for some auxiliary know-how and volunteer help.

*(Continued on page 109)*



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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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## Historians — Genealogists

# Physicians In Illinois History Project

Available records regarding physicians who practiced in Illinois prior to 1900 are somewhat sketchy. Some histories have been written about counties in Illinois. These provide data. Researchers have traced various groups of immigrants, which also is helpful. General works also provide pieces of information.

However, there is no one source which provides a listing of physicians in Illinois from the time of its first settlement by the French to 1900.

A project undertaken by the Illinois Genealogical Society, with Illinois Historical Society encouragement, and the Illinois State Medical Society, is to try to gather as much data as possible on these persons. It is no small task. A listing into

the thousands has been developed, but is very incomplete.

Assistance is needed. Anyone who has information on these early physicians is asked to share. Index cards will be provided, as well as extended biographical forms, to those who can provide information. Please address your request or comments to: Richard Ott, c/o *Illinois Medical Journal*, 55 East Monroe, Suite 3510, Chicago, IL 60603.

(In a related note, *IMJ* readers are reminded that the *History of Medical Practice in Illinois*, Volume II, is available at a cost of \$10 through the ISMS offices.)


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# I M J

*Illinois Medical Journal*

Vol. 157, No. 2, February, 1980

## California Group Virus Infections in Illinois

BY GARY G. CLARK, PH.D., RUSSELL J. MARTIN, D.V.M., M.P.H.,  
HARVEY L. PRETULA, CARL W. LANGKOP, M.S.P.H., AND H. H. ROHRER, M.D., M.P.H./  
CHICAGO, SPRINGFIELD AND PEORIA

*The California encephalitis virus group, designated CAL viruses, encompasses a number of antigenically-related arboviruses (arthropod-borne viruses). The first to be characterized, the California encephalitis virus (CEV), was isolated in 1943 from *Aedes melanimon* mosquitoes collected in Kern County, California<sup>1</sup> hence its name. Recent reviews of CAL virus literature point toward their significant role as human disease agents<sup>2,3</sup> and show that California encephalitis (CE) is the leading arboviral encephalitis recognized and reported in man in the United States.<sup>4</sup> From 1965 through 1974, excluding 1966 when St. Louis encephalitis (SLE) was at epidemic levels, there were 543 CE cases versus 282 SLE cases reported nationwide.<sup>5</sup> The CAL group now consists of 11 distinct members, including LaCrosse (LAC) virus—the member of this group that is most commonly associated with encephalitis in the U.S.*

LAC virus was originally isolated in 1964 from the brain of a four-year-old female meningoencephalitis fatality hospitalized in LaCrosse, Wisconsin.<sup>6</sup> She had expired in 1960. Major outbreaks, involving 43 patients, occurred in 1964 in Indiana<sup>7</sup> and Ohio.<sup>8,9</sup> A survey of reported arboviral encephalitis in the U.S. from 1955-1971 revealed that CE infections occurred predominantly in the upper midwest and included three Illinois cases.<sup>10</sup> The geographic focus in the midwest was

further reinforced in 1975, when four states (Illinois, Ohio, Minnesota and Wisconsin) accounted for 88% of all reported CE infections.<sup>5</sup> LAC is also regarded as the most significant human arboviral pathogen in Iowa.<sup>11</sup> Neutralizing (N) antibodies against Trivittatus (TVT) virus, another agent in the CAL group, were found in 1 of 59 human sera tested from southern Illinois.<sup>12</sup> This virus has not been established as a human pathogen.

Increasing concern among U.S. health professionals for CE infections has caused the authors to report Illinois' experience with CAL group infections. This paper, therefore, represents the first detailed account of the occurrence, laboratory diagnosis, clinical presentation, sequelae, transmission cycle, and potential for preventing CE infections (probably LAC virus) in Illinois. The reported endemic region for this virus includes virtually the entire state.<sup>13</sup>

### Laboratory Diagnosis

Etiologic confirmation of the infectious agent in patients with suspected arboviral encephalitis requires specific laboratory testing, which falls into two categories: serological studies and virus isolation. The former requires that two serum specimens, approximately three to five ml. each, be drawn from the patient. The acute phase specimen should be obtained as early after onset of illness as possible. The convalescent phase specimen should be drawn 14 to 28 days after the acute. These sera are tested simultaneously for the presence of hemagglutination-inhibition (HAI or HI) or complement-fixing (CF) antibodies. Since 1968, when antigens and reagents became available, the Virus Disease Section, Division of Laboratories, Illinois Department of Public Health (IDPH) has offered this service to Illinois physicians and laboratories. In addition to specific requests, and in an effort to identify additional cases, it has been the policy during summer months to test specimens collected from persons up to 16 years of age with any clinical syndrome suggesting central nervous system (CNS) involvement or fever of unknown origin (FUO).

If the patient expires, virus isolation should be attempted from portions of the brain that appear on gross examination to be affected, or from five ml. of whole, unclotted blood. The original isolation of LAC was made from inocula including portions of the posterior frontal lobe, midparietal region, pons, medulla, and cerebellum.<sup>6</sup> Tissue from different sites should be handled separately and submitted frozen on dry ice. In Illinois, serologic and isolation tests to detect CE infections are available only at the IDPH laboratory.

The importance of appropriate specimens for laboratory evaluation cannot be overemphasized. There is often reluctance to submit the convalescent serum specimen when little or no antibody is reported in the acute specimen. This initial reluctance may be compounded, since the patient has usually recovered and discharged from the hospital. Unless this individual is pursued, the

cause of encephalitis remains unknown. For those patients in whom a CE diagnosis is confirmed, the individual may not benefit directly but the etiological diagnosis may stimulate control efforts that will prevent future cases.

### Case Distribution

**Annual**—Although the first Illinois cases confirmed by the IDPH laboratory were reported in 1968, two earlier cases were observed in Illinois

FIGURE 1  
ANNUAL DISTRIBUTION OF CALIFORNIA ENCEPHALITIS CASES  
ILLINOIS, 1966 - 1978

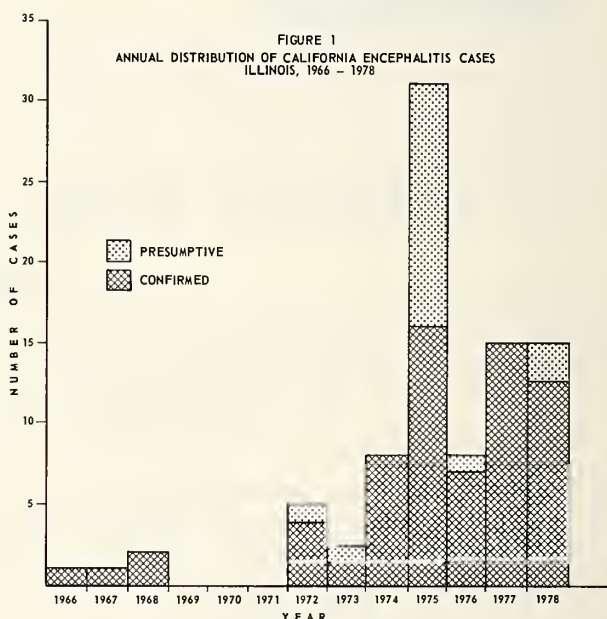
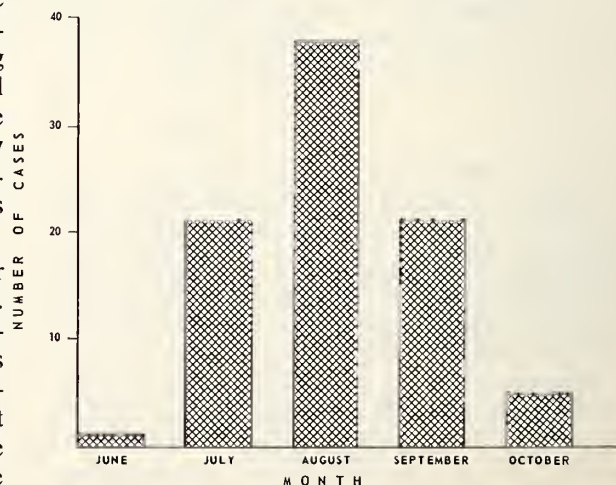


FIGURE 2  
MONTHLY DISTRIBUTION OF CALIFORNIA ENCEPHALITIS CASES  
ILLINOIS, 1966 - 1978





residents, one each in 1966 and 1967 (Fig. 1). These patients were hospitalized in Wisconsin and the diagnosis was confirmed by that state laboratory (Thompson, personal communication). Between 1968 and 1978, 86 cases were identified by IDPH, with 31 occurring in 1975. Sixty-eight were classified as confirmed (four-fold or greater change in HI titer or a single titer of 1:640 or greater) and 20 were classified as probable (single HI titer of  $\geq 1:80$ ). The year 1975 was also notable for the large number of cases of SLE in the state<sup>14</sup> and unexpectedly in Chicago.<sup>15</sup> No fatal CE infections have been identified in Illinois.

**Seasonal**—An epidemic curve typical of mosquito-borne virus infections emerges when the dates of onset of 86 cases are depicted (Fig. 2). In Illinois, onset of illness in 90% of cases has occurred between the second week of July and the third week of September, with the range from June 20 to October 11. The period from August 26 through September 1 has yielded the largest number (14) of cases. Since the disease is reported to have an incubation period of 3 to 7 days,<sup>16</sup> August remains the month when most infections are contracted in Illinois. Although Illinois data are similar to Minnesota data in this regard,<sup>16</sup> workers from Ohio<sup>17</sup> and Wisconsin<sup>18,19</sup> have found that September is the peak month of illness onset.

**Age**—Laboratory-identified cases of CE in Illinois have been reported in persons from five months to 77 years of age. Cases in the five to nine year age group accounted for 44 (51%) of 87 cases (Fig. 3). This is only slightly different

from that seen elsewhere.<sup>16,19</sup> The large proportion of cases in the five to nine year age group compared to the zero to four year age group may be a reflection of increased mobility. However, the small proportion of cases in the 10 to 14 year age group is not readily explained. The mean age of an Illinois case was 10 years and the mode was eight years. Only nine (10%) of the cases were over 16 years of age. It is interesting to note that during 1977 and 1978, the first cases under one year of age were detected. These cases included two males, five and 10 months of age, and one female, seven months of age.

**Sex**—A male:female ratio of 2.2:1 observed in Illinois (Fig. 3), has been less than the 2.9:1 reported from Wisconsin.<sup>19</sup> This ratio may be a reflection of increased mobility and play habits of young boys. Tree house and camping activities are known to have contributed to infections in several Illinois children.

**Geographic**—Although cases have been re-

FIGURE 4  
GEOGRAPHIC DISTRIBUTION OF CALIFORNIA ENCEPHALITIS CASES  
ILLINOIS, 1966-1978

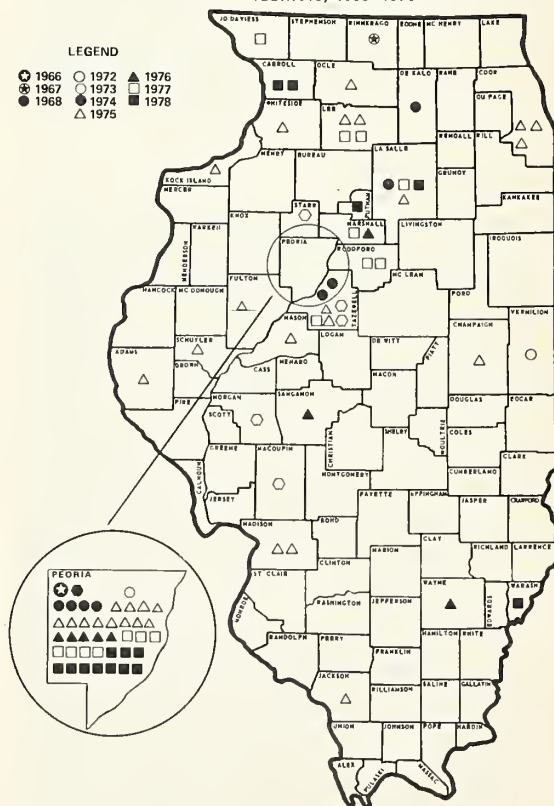
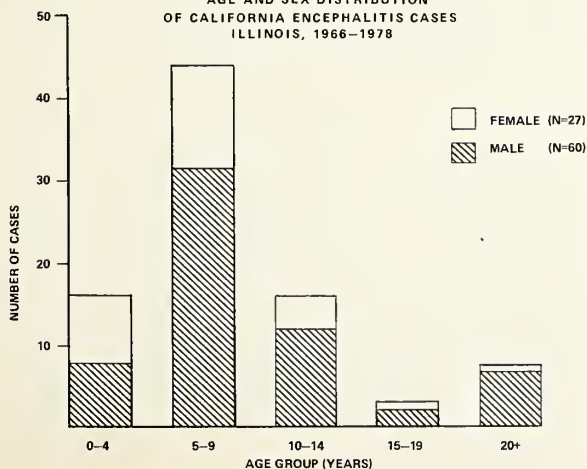


FIGURE 3  
AGE AND SEX DISTRIBUTION  
OF CALIFORNIA ENCEPHALITIS CASES  
ILLINOIS, 1966-1978



ported from 29 counties, 47% (41 of 87) of the reported cases resided in Peoria County (Fig. 4). Recent review of these incidence data has suggested that this apparent focus may be equally, or perhaps more intense than that in the La-Crosse, Wisconsin area where the LAC was originally isolated (Thompson, personal communication). When cases in Illinois and Wisconsin<sup>19</sup> are mapped, it is apparent that they are scattered around an imaginary line connecting foci in north central Illinois and southwestern Wisconsin. To date, over 90% of the Illinois cases have been reported from the northern half of the state. Several cases from Illinois counties that border other states have been diagnosed initially in Indiana, Iowa, and Wisconsin.

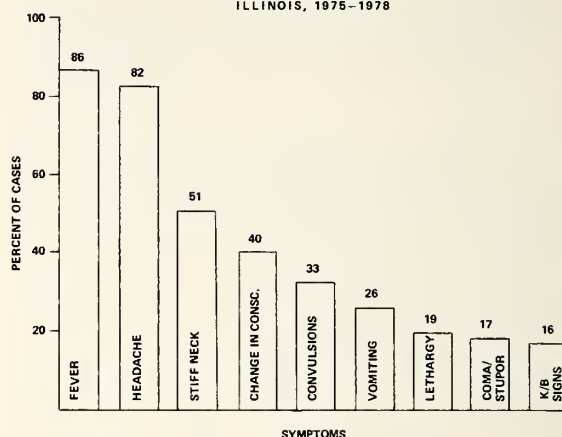
**Epidemiological Observations**—Interviews with cases (or parents) and on-site evaluations of the places of residence reflected a definite association in most cases with heavily wooded areas, a suitable habitat for the vector. In many instances, the patient reported that numerous mosquito bites had been received in the home environment. In others, illness was directly associated with attendance at a children's camp where mosquito bites were probably sustained. Recurrent annual transmission has been found in certain natural settings, exemplified by the occurrence of three cases (one in 1975, two in 1977) who resided in the same mobile home park. A similar occurrence was reported in Minnesota.<sup>20</sup>

### Clinical Presentation

The clinical syndromes reported in the United States have been typical of acute CNS infections, ranging from a mild, transient aseptic meningitis to severe encephalitis and death. The most common symptoms/signs were fever, headache, nausea and/or vomiting, nuchal rigidity, convulsions and lethargy.<sup>8,19</sup> Most patients had been hospitalized within two to three days after onset of illness, and the acute febrile stage of illness persisted for seven to 10 days. Focal neurological signs (*e.g.* paresis, paralysis, and aphasia) were common.<sup>2</sup> Severe and mild forms of the disease have been described.<sup>16</sup>

Hospital records of 57 Illinois patients, between 1975 and 1978, were reviewed. Signs and symptoms recorded for these patients are summarized. (Figure 5) Fever and headache were the most commonly reported findings, with stiff neck reported in just over 50% of the cases. Abdominal pain, paresis/paralysis, and tremor were each reported in seven percent of these patients.

FIGURE 5  
CLINICAL SYMPTOMS REPORTED  
FROM 57 CALIFORNIA ENCEPHALITIS CASES  
ILLINOIS, 1975-1978



Information concerning the "disease suspected and/or clinical symptoms" is requested on the cards that accompany serologic specimens submitted to the IDPH Virus Disease Section for examination. Since 1972, information accompanying the specimens from 71 cases included the following responses: encephalitis or meningoencephalitis (66%), aseptic meningitis (18%), viral studies (4%), fever of unknown origin (7%), seizures (3%), and convulsions (2%). In this group, 97% of the patients were hospitalized. The average length of hospitalization for 25 cases where data was available between 1975 and 1977 was 9.7 days.

Specimens for virus isolation were received from some patients in which CE was serologically diagnosed. During the past four years concurrent viral infections were identified in five of the 28 patients from whom these specimens were submitted. The viruses isolated and their sources were: adenoviruses from a six-year-old male (stool); ECHO 30 from a seven-year-old female (CSF) and a five-year-old male (stool); ECHO 22 (Nelson, personal communication) from a five-month-old male (stool); and ECHO 6 (Herrmann, personal communication) from a four-year-old male (throat, stool, CSF). Concurrent infections were reported from Minnesota<sup>16</sup> but workers in Ohio reported none.<sup>8</sup> The significance of dual infections is not clearly understood.

Virus isolation should be attempted on CE cases in an effort to further describe the magnitude of this phenomenon. Throat washings, CSF, and stool should be collected and submitted promptly, under refrigeration, to the IDPH Virus Disease Section.



## Sequelae

As with other diseases involving the CNS, there is concern regarding the long-term effects on patients. In 1966, follow-up visits with parents of Ohio patients yielded frequent complaints of "emotional lability, difficulty in learning in school, and personality problems."<sup>8</sup> A study of 35 infected children in Wisconsin revealed abnormal electroencephalograms (EEG) in 29% of the patients one to six years after onset of illness.<sup>21</sup> Two of these children had recurrent seizures, two had below average IQs, and one had persistent hemiparesis. In later reports on these children, 15 of 45 follow-up EEG tracings were abnormal; seizures were observed in 25 patients with six experiencing recurrent seizures.<sup>22,23</sup> Behavioral examinations made on 14 children, seven months to two years after hospitalization, revealed severe auditory and visual perceptual problems.<sup>24</sup> While there was no disturbance of higher language skills in this group, "organic" hyperkinetic personality syndrome was reported, resulting in a predictable behavior pattern associated with specific learning disorders. When a comprehensive psychological testing battery was administered one to six years after infection, to 33 serologically-confirmed cases hospitalized in Wisconsin, two showed below average psychometric intelligence and academic achievement.<sup>25</sup> Comparison of data from CE cases with data from normal control children yielded similar results both on cognitive-academic and personal-social measurements. A follow-up study of 33 Minnesota children, one to five years after acute illness, revealed five (15%) had sequelae.<sup>16</sup> Four had personality or behavioral problems such as lability, excessive irritability, and inattentiveness in school. The fifth had mild paresis of the left arm. All five had undergone severe illness. Six of eight follow-up EEGs taken for this group were abnormal. To date, no systematic evaluation of sequelae has been reported on Illinois cases.

## Transmission Cycle In Nature

The role of the mosquito vector, *Aedes triseriatus*, in the transmission of LAC was reported in 1972.<sup>26</sup> The female of this species, which is found in hardwood, deciduous forests of the Ohio and upper Mississippi Valleys, lays her eggs in tree-hole cavities or artificial containers in forested areas. These mosquitoes survive the winter in the egg stage. Small mammals, especially chipmunks and squirrels, have been implicated as a part of the reservoir in the natural transmission cycle of LAC virus.<sup>27,28</sup> Further studies, again in Wiscon-

sin where much of the basic research on this virus was conducted, revealed two additional modes of transmission among mosquitoes: transovarial<sup>29</sup> and venereal.<sup>30</sup>

Transovarial transmission is significant in that it may explain persistence of the virus in areas where mammals are scarce or absent. Furthermore, a female mosquito infected in this manner may be capable of transmitting the virus at the time she takes her first blood meal. In contrast, the transmission of many arboviruses requires that the female acquire virus from a viremic host followed by an extrinsic incubation period prior to transmitting virus to a susceptible host. Recent work in an LAC focus (Clark, unpublished data) has confirmed that transovarial transmission occurs in Illinois and that the vertebrate cycle involves small mammals.

Fortunately, the mosquitoes that transmit LAC generally restrict their activity to wooded areas and do not fly long distances. Therefore, the chances of becoming infected are greatly enhanced when entering a wooded area where infected *A. triseriatus* reside. Similarly, the probability of widespread outbreaks, such as those observed with an avian-mosquito virus (*i.e.*, SLE), is reduced since the vertebrate and arthropod hosts for LAC are less mobile.

## Preventive Measures

Recognizing that current therapy for this arboviral infection is primarily supportive<sup>6,7</sup> and that the disease probably will not occur at epidemic levels like SLE virus, it is important to identify as many cases as possible in order to define new foci or recent expansion of known LAC transmission foci. If more physicians consider this infection in their differential diagnosis, requests for serologic testing should increase, and more cases will probably be identified.

Once cases are recognized, high incidence areas can be defined and specifically characterized by mosquito-mammal studies. Patrons of parks, campgrounds, recreational areas or residential areas can then be educated to the potential hazards and specific environmental treatments that might be utilized. These persons can be advised to avoid mosquito bites by use of repellents or altering activities. Studies have revealed that *A. triseriatus* feed predominantly in the afternoon before 6:00 p.m., DST.<sup>31</sup> Closure of basal tree-holes has been attempted in Wisconsin<sup>32</sup> where Thompson, Gunderson and co-workers (unpublished data) have suggested that a reduction in serologically confirmed cases occurred as a result. A recent modification of this procedure has been

developed<sup>33</sup> but, in general, more effective control measures are dependent upon a better understanding of all transmission cycle components.

### Future Considerations and Implications

In 1978, a 10-day-old child from southeastern Minnesota was diagnosed as having an LAC viral infection (Gunderson and Thompson, personal communication). The mother had antibodies to the virus. Since the child reportedly had limited potential for mosquito exposure, this suggests the possibility of transplacental or milk-borne transmission. This mode is feasible since other arboviruses have these capabilities.<sup>34-36</sup> Investigators in Wisconsin are actively pursuing the mode of transmission in this case.

Few large-scale serologic surveys have been conducted. One 1973 study, conducted in three Ohio endemic areas,<sup>37</sup> revealed 102 (5.6%) of 1,825 children between six and 18 years of age were serologically positive to CAL viruses. A study of 637 sera from several groups of Wisconsin residents with different outdoor occupations reported 9.5 to 34.2% with N antibodies to CAL viruses.<sup>18</sup> In a previous study in Wisconsin, 51 (35%) of 144 wildlife workers from several areas of the state had N antibodies to CAL viruses.<sup>38</sup>

A large serosurvey using LAC virus antigen was conducted in urban (1,237) and rural (667) residents near Winona, Minnesota in 1968.<sup>39</sup> In this enzootic area, the rural population had 13% with HI and 26.8% with N antibodies. In contrast, the urban group only had 4% with HI and 15.3% with N antibodies. Possible human infections due to TVT virus were suggested. Additional surveys of a similar nature are needed to further delineate the extent of the problem based on results of the above studies.

Grimstad<sup>40</sup> pointed out, "Our greatest need today in Indiana is case recognition of the disease . . .," a statement that should certainly be echoed in Illinois, especially during summer and early fall. ◀

### Acknowledgment

We would like to recognize the physicians, laboratory, and local health department personnel who have been helpful in securing clinical information epidemiologic data, and convalescent serum specimens from patients.

### References

A complete list of references for "California Group Virus Infections in Illinois," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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# Non-Invasive Localization of Pheochromocytoma in Childhood

BY D. V. DADO, M.D., A. L. BARBATO, M.D., AND R. J. FREEARK, M.D./MAYWOOD

*Pheochromocytoma occurs in childhood in less than 5% of all cases;<sup>1</sup> and indeed, in 178 cases at the Mayo Clinic between 1926 and 1975, only four have occurred in children (15 years old or younger).<sup>2</sup> This case report demonstrates the common clinical aspects of pheochromocytoma in childhood and some atypical manifestations. It further demonstrates that diagnosis and localization should be accomplished with non-invasive techniques. The significant morbidity and mortality of invasive methods such as arteriography and venography are also discussed.*

A 16-year-old black female was transferred to Loyola University Medical Center for evaluation and treatment of refractory hypertension. Her chief complaint was frequent headaches for two months, becoming more persistent and severe prior to hospitalization. Notable irritability and blurred vision were evident as the headaches evolved. At age 14, the patient had undergone a normal childbirth without hypertensive complications. One paternal great-grandmother had died of hypertension.

Upon examination, the patient was a thin female with marked diaphoresis. She had a sinus

tachycardia of 130 beats per minute and her blood pressure was 160/130 supine and 140/100 standing; similar in both upper extremities. Fundoscopic exam revealed arteriovenous narrowing. The thyroid was not enlarged, there were no abnormal heart sounds and no palpable abdominal masses. Peripheral pulses were intact and symmetrical.

Routine chest X-rays, including lateral and oblique views, demonstrated a normal heart size and clear lung fields. An intravenous pyelogram with nephrotomography showed both kidneys, ureters, and bladder to be normal in size, shape and position without surrounding masses. The patient's laboratory values are reviewed in Table 1.

On admission, the patient was controlled on phenoxybenzamine, 20 mg. orally every day and propranolol, 10 mg. orally every four hours. Further studies were for localization. Abdominal Gray Scale Ultrasound demonstrated a 4.8cm homogenous, solid mass above the right kidney (Figure 1). Computer assisted tomography was attempted, but for technical reasons, could not be completed.

Pre-operatively, the patient received intravenous fluids to correct mild, chronic hypovolemia. Afterward, she complained of blurred vision and became hypertensive and tachycardic. Increasing the propranolol, administering phenoxybenzamine intravenously and adding intramuscular phentolamine did not have a lasting effect in controlling her blood pressure. Therefore, she was begun on intravenous sodium nitroprusside with successful control.

A transabdominal exploration revealed a tumor mass involving the right adrenal gland and a somewhat hypoplastic left adrenal gland. A right



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Table 1

	Patient Values	Normal Range
Serum Sodium	137 mEq/L	132-145 mEq/L
Serum Potassium	3.9 mEq/L	3.6-5.4 mEq/L
Serum Chloride	93 mEq/L	95-107 mEq/L
Serum Osmolality (Calculated)	269 mOsm/kg	270-290 mOs/kg
Serum Osmolality (Measured)	281 mOsm/kg	270-290 mOsm/kg
Difference (M-C)	12 mOsm/kg	5-20 mOsm/kg
Serum Glucose (Fasting)	95 mg%	70-100mg%
Serum Bun	12 mg%	8-20 mg%
pH (Venous)	7.43	7.32-7.45
pCO <sub>2</sub> (Venous)	44 mm Hg	35-50 mm Hg
Hematocrit	38.1 %	42 ± 5 %
Hemoglobin	13.0 gms	14 ± 2 gms
SMA-12	NORMAL	NORMAL
Total Metanephrines (Urine)	10.3 mg/24 hrs.	0.3-0.9 mg/24 hrs.
Vanillilmandelic Acid (Urine)	48.1 mg/24 hrs.	0.7-6.8 mg/24 hrs.
Epinephrine (Urine)	326 mcg/24 hrs.	
Norepinephrine (Urine)	1795 mcg/24 hrs.	E:N::1:3
Total Catecholamines (Urine)	2121 mcg/24 hrs.	≤ 135 mcg/24 hrs.
Plasma Renin Activity (As Angiotensin I/ 6:00 A.M. Supine Low Salt Intake)	5.7 ng/ml/hr.	0.7-7.1 ng/ml/hr.
Serum T3 uptake Ratio	0.95	0.82-1.19
Serum T4 by RIA	7.0 mcg/100 ml	5-12 mcg/100 ml

adrenalectomy was successfully performed. The pathologic specimen demonstrated a pheochromocytoma of the right adrenal gland, weighing 65 grams. The tumor was completely encapsulated. The patient was placed on steroid supplementation during her immediate post-operative course due to the hypoplasia of the left adrenal gland. On the eighth post-operative day, she was discharged from the hospital with supine and standing blood pressures in the range of 120/88 and 110/80 respectively. No antihypertensive medications were prescribed upon discharge.

### Discussion

The common symptoms of pheochromocytoma in childhood include nausea, abdominal pain, weight loss, diaphoresis, visual changes, and convulsions.<sup>2-5</sup> In approximately 90% of children, the hypertension is sustained,<sup>3,5</sup> during which time there may be hyperglycemia, fever, and elevated blood and urine catecholamine levels.<sup>3</sup> Sixty-two percent of pediatric cases occur between the ages of 11 and 15 years,<sup>5</sup> including a preponderance of females presenting around the menarche. Pheochromocytomas often become symptomatic with pregnancy. As of 1972, 93 cases of pheochromocytoma occurring during pregnancy had been reported<sup>6</sup> with a 48% overall mortality

rate.<sup>3</sup> It is of interest that this patient sustained a normal pregnancy and delivery one year prior to the onset of her symptomatology.

This case illustrates that the diagnosis and localization of pheochromocytoma is usually successful without invasive procedures. The differential diagnosis of hypertension in childhood includes renovascular disease, coarctation of the aorta, adrenal cortical hyperplasia, and neural crest tumors. These can be ruled out by the clinical presentation and characteristic laboratory abnormalities. This patient had normal peripheral pulses and similar blood pressures in both extremities ruling out coarctation of the aorta. She had normal electrolytes and plasma renin levels to rule out hyperaldosteronism and her clinical symptoms and catecholamine levels were characteristic of pheochromocytoma. Further, a mass was demonstrated on ultrasound.

In children, about 25% of pheochromocytomas are bilateral, and in the first 100 published cases, 31% were extra-adrenal and 32% were multiple.<sup>6</sup> This clearly demonstrates the need for pre-operative localization and complete surgical exploration.

Classically, the localization of pheochromocytoma has been accomplished using retroperitoneal oxygen or carbon dioxide insufflation com-





**Figure 1**

**Abdominal Gray Scale Ultrasound demonstrating a 4.8cm. homogenous, solid mass with low echo pattern above the right kidney. L=liver, K=kidney and arrow points to mass.**

bined with aortography. In the past, the only additional localization procedures included selective arteriographic studies or venography with selective blood samples for catecholamine levels. With angiography, there is risk of hypertensive crisis as well as adrenal or peri-adrenal hemorrhage if dye is injected into the arterial side of a catecholamine-producing tumor.<sup>8</sup> Frequently, when the aortogram does not give sufficient radiographic detail, selective catheterization is performed, increasing these risks. In a review by Rossi,<sup>9</sup> 52% of patients undergoing retrograde catheterization had wide fluctuations of blood pressure or severe systolic hypertension. In 18 cases that had translumbar catheterization, there were three deaths. These studies were performed with diodrast and/or urokon dye which are no longer used, lessening the still present danger.

Hypertensive crises and adrenal hemorrhage have also occurred after venography.<sup>10,11</sup> Also, in 15 to 30% of patients, the right adrenal vein cannot be catheterized, limiting its usefulness.

With these facts in mind, most authors now agree that invasive techniques should be reserved for pheochromocytomas not found at a surgical exploration. Supporting this position are the several noninvasive localization procedures available today. Negative chest roentgenograms with oblique views can virtually exclude tumor in the

chest.<sup>3</sup> Intravenous pyelography with bolus nephrotomography demonstrated approximately 90% of all pheochromocytomas.<sup>4</sup> In 124 cases of adrenal tumors reviewed from the Mayo Clinic, including pheochromocytomas, there were no hypertensive crises and no deaths with intravenous pyelography.<sup>7</sup>

Using conventional techniques, normal adrenal glands are not visualized as distinct structures on abdominal ultrasound. However, adrenal glands or masses equal to or greater than 3cm. are identified due to their homogenous internal texture and sharp, capsulated margins.<sup>12</sup> Using new techniques and improved equipment, Sample has reported the visualization of normal adrenal glands<sup>13</sup> thus, potentiating the efficacy of ultrasound in evaluating adrenal pathology.

The role of computer assisted tomography as a valid, non-invasive, localization procedure is well established. If the normal adrenal glands are visualized (a normal left gland is seen in 80% of cases and a normal right gland in 50% of cases), then lesions as small as 1cm. can be identified due to the distortion of the normal outline of the gland.<sup>14</sup> In a recent series, 10 of 11 patients with pheochromocytomas had successful localization with computerized tomographic scanning.<sup>15</sup>

Localization of pheochromocytoma should be done with safe, non-invasive methods including intravenous pyelography with nephrotomography, ultrasonography, and computer assisted tomography. The availability and expense of the latter can limit its usefulness, stressing the primary importance of the former two techniques. The higher risk procedures of arteriography and venography should be reserved for cases in which tumors are not found with non-invasive means or not found at surgical exploration. ◀

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# Viewbox

(Continued from page 85)

This man stopped smoking one year ago after averaging two-three packs of cigarettes per day for many years. He had a lobectomy soon after these films and the lesion was a necrotic cavitory squamous bronchogenic carcinoma. Twenty lymph nodes were negative for neoplasm.

All choices given can cause thin walled cavities, except Wegener's granulomatosis, which is characterized by thick walled cavities. When the infectious diseases listed present with thin walled cavities, the cavities are further characterized by uniform width. The cavity in this case has a non-uniform, irregular wall which should always be suspect for malignancy. The air fluid level (Figure 1) can be seen in infection or cavitory neoplasm.

Bronchogenic carcinoma is most commonly discovered on radiographs as a solitary mass. Most carcinomas originate in segmental airways and radiographs often reflect airway obstruction with presentation initially as atelectasis or alveolar consolidation usually with some loss of volume. Unilateral hilar enlargement is also a frequent sole finding. Presentation of bronchogenic carcinoma as a cavitory mass is less common but does occur in 5-10% of cases.<sup>1</sup>

Cavitation can result from (A) infection with abscess formation distal to the obstructing neoplasm, (B) partial obstruction with infected material spilling over to other parts of the lung and subsequent abscess formation, or (C) cavitation of the neoplasm itself.<sup>2</sup>

Most necrotic neoplasms are thick walled. Rarely the wall is thin and mimics an infectious cavity or bulla. Again, however, irregularity of the wall usually signals malignancy.

Most cavitated bronchogenic carcinomas are squamous with large cell and adenocarcinoma much less common. Oat cell carcinoma almost never cavitates. Cavitation is most likely the result of ischemia secondary to vessel occlusion by tumor thrombi.<sup>3</sup>

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# Obituaries

**\*\*Barnsback, Lester J.**, died January 2, 1980, at the age of 101. Dr. Barnsback was a graduate of the University of Illinois Medical School.

**\*\*Bell, Clarence Elliott**, Decatur, died December 21, 1979, at the age of 77. Dr. Bell was a 1928 graduate of the University of Pennsylvania.

**\*Burack, Samuel**, Chicago, died January 10, 1980, at the age of 67. Dr. Burack was a 1937 graduate of the University of Illinois Medical School. He had served on the staff of the West Side Veterans Administration Hospital.

**\*Cunningham, James T.**, Springfield, died December 23, 1979, at the age of 63. Dr. Cunningham was a 1941 graduate of the University of Illinois.

**\*Feldser, Vernon A.**, Chicago, died December 9, 1979, at the age of 68. Dr. Feldser was a 1938 graduate of the Chicago Medical School.

**\*\*Gernon, Gerald Deland**, Champaign, died November 22, 1979, at the age of 86. Dr. Gernon was a 1920 graduate of the University of Illinois Medical School.

**\*\*Kronfeld, Peter C.**, Wilmette, died January 1, 1980, at the age of 80. Dr. Kronfeld was a 1923 graduate from Wein, Austria.

**\*Lorang, John J.**, Antioch, died December 9, 1979, at the age of 53. Dr. Lorang was a 1956 graduate of the Loyola University Stritch School of Medicine. He had served on the staff at Victory Memorial Hospital and was a member of the Blumberg Blood Bank in Waukegan.

**\*\*Mintek, Stanley J.**, Oak Park, died December 25, 1979, at the age of 89. Dr. Mintek was a 1922 graduate of the Chicago Medical School.

**\*\*Nelson, Caryl Linder**, Crystal Lake, died October 9, 1979, at the age of 87. Dr. Nelson was a 1916 graduate of the Northwestern University School of Medicine.

**\*\*Schweiger, Leo J.**, Chicago, died October 3, 1979, at the age of 82. Dr. Schweiger was a 1925 graduate of the Northwestern University School of Medicine.

**\*Strasser, Noel Faine**, LaGrange Park, died December 10, 1979, at the age of 50. Dr. Strasser was a 1953 graduate of George Washington University in Washington D.C.

**\*Stocker, Jesse A.**, Springfield, died January 11, 1980, at the age of 70. Dr. Stocker was a 1933 graduate of the University of Minnesota.

**\*Taylor, Kenneth Robert**, River Forest, died December 19, 1979 at the age of 73. Dr. Taylor was a 1939 graduate of the Chicago Medical School.

**\*\*Unger, Leon**, Chicago, died December 17, 1979, at the age of 88. Dr. Unger was a 1915 graduate of Rush Medical College.

**\*\*Varney, Harley Roosevelt**, Kewanee, died November 2, 1979, at the age of 76. Dr. Varney was a 1932 graduate of the University of Illinois Medical School.

**\*Waterbury, David A.**, Marion, died December 9, 1979, at the age of 62. Dr. Waterbury was a graduate of the Kirksville College of Osteopathy and Surgery, in Kirksville, Missouri.

\* Indicates ISMS member

\*\*Indicates ISMS member of the fifty year club

## Toward Quantitative Clinical Judgment

# Anemia, Hyperglobulinemia, and Plasma Cells in the Blood

BY RODNEY B. NELSON, M.D., MANJEET CHAWLA, M.D., AND  
JOSEPH LAPORTE/CHICAGO

*Anemia and hyperglobulinemia are cardinal manifestations of multiple myeloma, but very non-specific. The finding of plasma cells in the peripheral blood smear is one of the diagnostic criteria for multiple myeloma. We have shown that plasma cells do appear more frequently in the blood of myeloma patients than in the blood of patients with secondary hyperglobulinemia and are not found in the blood of patients with other miscellaneous hematologic conditions. However, an application of Bayes' formula in an attempt to quantitate clinical judgement would indicate that a patient at our institution with anemia, hyperglobulinemia, and plasma cells in the peripheral blood still has less than a 1% chance of having myeloma if the first two findings can be explained on the basis of an already apparent diagnosis. This provides some formal justification for the law of parsimony in diagnosis, and has implications for cost effective management.*

Examination of the peripheral blood smear often gives important clues to diagnosis<sup>1</sup> and is a time honored part of the data base in hospitalized patients. At our hospital a multichannel blood chemistry analysis which includes total

protein and albumin is also part of the data base. The presence of plasma cells in the peripheral blood has been considered one of the diagnostic criteria for multiple myeloma.<sup>2</sup> Our patients often suffer from chronic illnesses that result in anemia and hyperglobulinemia. Not infrequently, patients are referred to the hematology service because of anemia and hyperglobulinemia, and one or more plasma cells is found by a clinician or reported by the laboratory in the peripheral smear. The hematologist may then feel obliged to leave no element of doubt about the diagnosis of multiple myeloma and proceeds to bone marrow, metastatic bone X-ray survey, quantitative immunoglobulins, and other investigations. This diagnostic zeal is spurred particularly by the presence of plasma cells in the blood.

This study was undertaken to assess the quantitative impact that plasma cells in the blood should have on clinical judgment in a setting where anemia and hyperglobulinemia could be explained on the basis of another readily apparent diagnosis. To plan a cost effective evaluation, the clinician must have at least an informal idea about how a single positive test or finding affects

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MANJEET CHAWLA, M.D., is a clinical assistant professor of hematology at the Loyola University Foster G. McGow Memorial Hospital in Maywood, Illinois. A board certified internist, Dr. Chawla was an associate in medicine at the UI Hospital in Chicago at this writing.

JOSEPH J. LAPORTE is a hematology technician at the Veterans Administration West Side Medical Center in Chicago.



**Table 1**  
**Bayes' Formula**

$$P(D+/T+) = \frac{P(D+) P(T+/D+)}{P(D+) P(T+/D+) + P(D-) P(T+/D-)}$$

**Where:**

**D+** means that myeloma is present

**T+** means that anemia and hyperglobulinemia are present

**D-** means that myeloma is not present

**and: P(T+/D+) = probability of anemia and hyperglobulinemia with myeloma present or sensitivity of positive test**

**P(T+/D-) = probability of anemia and hyperglobulinemia with myeloma absent or 1 - specificity of a positive test**

**or, in this case:**

$$P(\text{myeloma}) = P(D+) = 6/3854 = 0.0015$$

$$P(\text{anemia and hyperglobulinemia present/myeloma present}) = P(T+/D+) = 0.80^*$$

$$P(\text{myeloma absent}) = P(D-) = 1 - P(D+) = 1 - 6/3854 = 0.9985$$

$$P(\text{anemia and hyperglobulinemia present/myeloma absent}) = P(T+/D-) = 0.42^{**}$$

**Which gives a probability of myeloma being present when there is anemia and hyperglobulinemia of 0.003.**

*\*determined by the fact that 20 of the 25 myeloma cases had anemia and hyperglobulinemia.*

*\*\*determined by the fact that 21 of 50 consecutive non-myeloma admissions to the medical service had anemia or hyperglobulinemia.*

the probable presence of a given disease. Inherent in this process is an estimate of the sensitivity, specificity, and cost of the test, plus an estimate of the probability of the disease being present prior to the test. While this may seem simple and obvious, intuitive responses to such a situation are often wrong.<sup>3,4</sup>

### Methods

Peripheral blood slides stained with standard Wright's stain from three separate sources were employed. The first group was 25 consecutive cases of multiple myeloma beginning with January 1, 1971 through December 31, 1974. The second group included 25 consecutive cases referred to the hematology service over the last three months of 1974 for anemia and what was felt to be secondary hyperglobulinemia (cirrhosis 10, rheumatoid arthritis 3, tuberculosis 3, sarcoidosis 2, miscellaneous malignancies 5, others 5). Finally, 25 cases from a single day in the hematology clinic (myeloma excluded) were assigned random numbers from a table and included in the study.

A label was placed over all identifying marks. The cases of myeloma were diagnosed by standard criteria<sup>2</sup> and cases with secondary hyperglobulinemia were shown not to have M-protein, Bence-Jones proteinuria, lytic bone lesions, or

sheets of plasma cells in the bone marrow. Peripheral blood smears were examined by a senior laboratory technician who was told only that we were interested in the presence of plasma cells. He was not told how many slides were from myeloma patients. To simulate standard clinical practice, he first performed standard 100 cell count differentials. Then he did an additional 100 lymphocyte differential as might be done by a clinician searching for plasma cells. The lymphocytes were categorized as normal small, normal large, immunoblast-atypical plasmacytoid, or plasma cells. To minimize the possibility of excessive false positive plasma cell identification, the technician was told to call a cell a plasma cell only if there were abundant deep blue cytoplasm, well defined peri-nuclear clear zone, and an eccentric nucleus with a "wheel spoke" chromatin configuration.

The initial probability of myeloma before the identification of plasma cell was estimated by dividing the total number of new cases of myeloma in a single year (six) by the total number of admissions to the medical service in that year (3854). This figure was adjusted for the presence of anemia and hyperglobulinemia through the use of Bayes' formula, which is an algebraic formula for relating the prevalence of a

Table 2

$$P(D+*/T+*) = \frac{P(D+*) P(T+*/D+)}{P(D+*) P(T+*/D+) + P(D-*) P(T+*/D-*)} = 0.009$$

where:  $P(D+*) =$

probability of myeloma after adjusting for anemia and hyperglobulinemia = 0.003 (see above)

T+\* means in this case presence of plasma cells in the blood

$P(T+*/D+) = 10/25 = 0.80$

$P(T+*/D-*) = 2/25 = 0.12$

disease and the sensitivity and specificity of a test to the probability of a disease in a given patient. The formula may be applied sequentially in the case of multiple independent tests. (Table 1)

## Results

Plasma cells were identified in the peripheral smears in 10 of 25 myeloma cases (eight during the course of the routine differential). In the secondary hyperglobulinemia group, plasma cells were identified in three smears (two during the course of the routine differential). None of the smears from the 25 hematology clinic patients had plasma cells. Chi square test for independence of the three groups is significant at  $p=0.01$ . The difference between the myeloma group and the secondary hyperglobulinemia group was significant at  $p=0.05$  by Fisher's exact test. The mean number of plasma cell positive slides was 3.3 in the myeloma group and 2.3 for the secondary hyperglobulinemia group (not significant by  $t$  test).

Thus the probability of myeloma given anemia and hyperglobulinemia plus one or more plasma cells in the blood can be evaluated as shown in Table 2.

This gives a final probability of multiple myeloma presence of less than 1% when a patient has anemia, hyperglobulinemia, and plasma cell(s) in the blood *when the first two findings can be explained on the basis of a known existing condition.*

## Discussion

These results do not imply that the finding of peripheral blood plasma cells in the setting of unexplained anemia or hyperglobulinemia is unimportant. Nor should plasmacytosis of 2% or greater be ignored on the basis of the data presented here. Further, the results cannot be uni-

versally applied, since all the prior probabilities are tied to the population from which the patient is drawn. But we have attempted to construct a model of quantitative clinical judgment designed to aide in the use of data acquired in daily practice and to add a very rough quantitative justification to the law of parsimony in diagnosis (and diagnostic tests). In a situation where three cardinal manifestations of a rare disease occur, but two can be explained on the basis of an existing disease, addition of the third finding does not necessarily raise the probability of the rare disease to high levels. The primary physician may be well advised to seek additional information through inexpensive means (at the bedside) or through existing data. (Is the total protein very high? Is the anemia disproportionate to the severity of the underlying disease?) rather than through the application of additional expensive technology. The consultant must be aware of the determinants used by the primary physician in deciding to seek his advice and not apply technology by rote. The "test of time" will always occur and may add no additional cost or risk. "To be uncertain is to be uncomfortable, but to be certain is to be ridiculous."<sup>6</sup> ◀

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# Surgical Grand Rounds

John M. Beal, M.D., Contributing Editor

*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of October 30, 1979.*

## Case Report:

## Peri-ampullary Carcinoma

**Dr. Diane Gerber:** The patient is a 62-year-old man who had awakened at night three months previously with severe sharp abdominal pain. He described the pain as mid-epigastric, nonradiating, and not accompanied by nausea or vomiting. The pain resolved spontaneously after several hours. He denies previous similar or subsequent pain and there was no history of fatty food intolerance, change of skin color, change of bowel habits or melena. Nausea, vomiting or anorexia were absent. However he did have a residual soreness in the mid epigastric area and finally sought consultation approximately one month later from his family physician. His doctor noted that he had a 15 pound weight loss, icterus and mid epigastric and right upper quadrant tenderness. He immediately admitted the patient to a hospital for evaluation. His blood chemistry values were compatible with obstructive jaundice. An upper G.I. series, abdominal ultrasound and CAT scans were obtained.

**Radiology:** The upper gastrointestinal radiographs were obtained from the hospital in New Jersey. The stomach appeared normal; however, there was irregularity of the duodenal mucosa in the region of the papilla of Vater (Figure 1). There was no obstruction to the flow of the barium meal and the duodenal C loop was not widened. An ultrasound examination was also

performed. The sonogram demonstrated a dilated gall bladder. Evidence of distended bile ducts was also noted (Figure 2). In addition, a CAT scan was obtained. There was better delineation of the pancreatic bed than in the ultrasound study. The pancreas seemed a little more homogeneous than normal but did not appear enlarged. The gall bladder was distended but there was no evidence of a mass in the head of the pancreas, nor were biliary tract stones detected.

**Dr. Diane Gerber:** Endoscopy was then performed and revealed a periampullary duodenal lesion that protruded from the mucosa. Multiple biopsies were taken and were reported as demonstrating cellular atypia. Exploration was then performed. The duodenum was opened and the papilla of Vater was excised. Frozen section again showed atypical cells. However, permanent sections demonstrated carcinoma. The patient was referred to the Northwestern Memorial Hospital for definitive treatment. His past medical history included smoking for 40 years and chronic obstructive pulmonary disease. Significant cardiovascular disease or diabetes mellitus was absent. His father had died at the age of 68 of carcinoma of the stomach. On physical examination the patient was found to be a well developed, obese white male without acute distress.

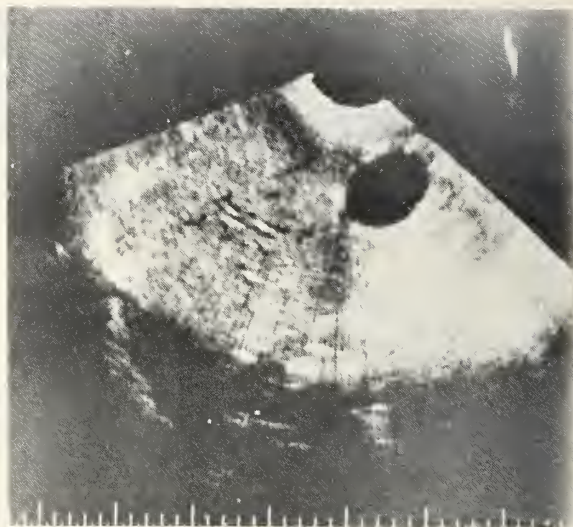


**Figure 1**

Upper gastrointestinal X-rays demonstrated a filling defect in the duodenum in the region of the papilla of Vater.

He was afebrile, blood pressure 150/90, pulse 90, and respirations 20. He was not icteric. Chest examination revealed hyperresonance and decreased excursion of the pulmonary cage. His abdomen was slightly obese, normal bowel sounds were present and the liver span was normal. There were no abdominal masses or tenderness. Stool was guaiac negative. Admission laboratory data included an alkaline phosphatase level of 106 units, bilirubin 1.6, LDH 252, SGOT 66, CPK 197, BUN and creatinine were normal. Hematocrit was 38.9. His pulmonary function tests were compatible with mild obstructive pulmonary disease and EKG was normal.

On the ninth of September radical pancreatoduodenectomy was performed. At the time of operation, the gall bladder, cystic and common ducts were found to be dilated. The liver was free of metastases. Gastrointestinal continuity was restored by invaginating to end of the pancreas into the jejunum. The end-to-side choledochyjejunosomy was accomplished and a gastrojejunosomy performed. A truncal vagotomy had been done early during the operation. A sump



**Figure 2**

The gall bladder is dilated in this ultrasound study. The gall bladder is seen in the upper portion of the scan on the right.

drain was placed near the pancreas and three Penrose drains were placed near the foramen of Winslow.

**Dr. Ryoichi Oyasu:** The specimen we received consisted of the distal third of the stomach, the entire duodenum, a portion of the pancreas, the distal portion of the common bile duct and the mesentery. The external surface of the specimen revealed no significant abnormality except for patchy fat necrosis on the surface of the pancreas. The common bile duct was slightly dilated but appeared otherwise unremarkable. The common bile duct was mildly dilated. Its distal end formed a very short common channel with the pancreatic duct. As is shown in Figure 3, a broad-based polypoid mass was found within this common channel, and extended for a short distance into the common bile duct. The mass measured 0.7 x 0.8 x 0.4 cm.

Microscopic examination revealed a papillary carcinoma projecting into and almost totally obstructing the lumen (Figure 2). In general, it was a well differentiated papillary adenocarcinoma with minimal cytological atypia (Figure 4), but in the sections obtained from the area away from the ampulla, the tumor was less well differentiated. The sections studied did not demonstrate invasion of the submucosa. All 12 regional lymph nodes submitted for study were free of metastasis. The remainder of the specimen, including the gastric and duodenal mucosa,





**Figure 3**

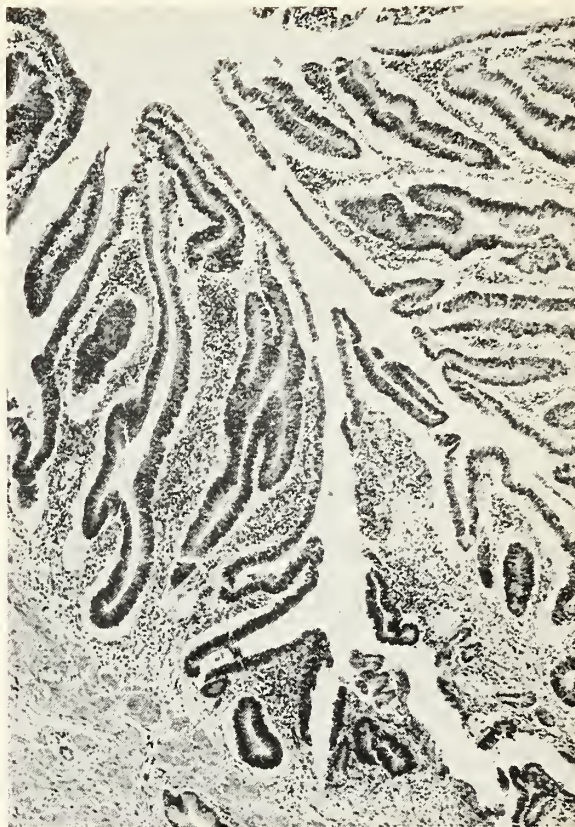
A polypoid mass was found within the ampulla of Vater.

sections of the gall bladder, and the pancreatic and common bile ducts, revealed no significant abnormality. The final diagnosis was a grade II papillary adenocarcinoma of the ampulla of Vater and distal common bile duct.

**Dr. Diane Gerber:** The patient's postoperative course was uneventful and he was sent home on the 16th postoperative day.

#### Review of the Literature

**Dr. Joseph Michelotti:** Three major digestive tract organs, the duodenum, the pancreas and the common bile duct, converge at the ampulla of Vater. Carcinoma which occurs within 2cm of the papilla is considered as periampullary carcinoma and may produce similar symptoms. Both diagnosis and treatment of these neoplasms may be difficult. Although they are pathologically distinct, they are as closely related clinically as they are anatomically. Cancer of the pancreas comprises approximately four percent of all malignant tumors in the United States and caused about four percent of the cancer deaths in 1978. Carcinoma of the pancreas is the most common cancer of the periampullary region and comprises about 80% of these neoplasms. Carcinoma of the ampulla is a poor second at approximately 12%, and eight percent arise in the common duct and duodenum. The majority of periampullary tumors are adenocarcinoma. Occasionally, benign islet cell tumors arise in the pancreas and benign villous adenomas may develop in the duodenum but do not produce icterus. Common duct neoplasms are almost always malignant although a benign common duct tumor was removed at this institution several



**Figure 4**

Microscopic examination revealed a well differentiated papillary adenocarcinoma.

years ago. Although painless progressive jaundice has been said to be typical of pancreatic carcinoma, approximately 80% are associated with pain. Such pain is often vague, dull and may radiate to the back. Periampullary tumors sometimes produce intermittent jaundice secondary to recurrent central necrosis and tumor slough. Weight loss is common. Occult blood in the stool suggests ampullary carcinoma. A palpable abdominal mass is usually a grave sign. A distended gall bladder is palpable in about half the cases. Useful radiologic studies include upper gastrointestinal X-rays with hypotonic duodenography and percutaneous transhepatic cholangiography. Carcinoma in the head of the pancreas may cause anterior displacement in the stomach, flattening of the mucosal folds in the stomach and duodenum and the reverse of those signs. Duodenal lesions may be visualized with gastro-duodenoscopy and biopsy. Percutaneous cholangiography is useful in distinguishing common duct lesions from pancreatic lesions in the jaun-



diced patient. The rat-tailed deformity of the common duct is characteristic of pancreatic compression of the common duct. Endoscopy is, of course, indicated in most of these patients and may provide a tissue diagnosis if the lesion involves the duodenal mucosa, as previously mentioned. Endoscopic retrograde cannulation of the ampulla promises to be a valuable diagnostic tool as well. Ultrasonography, computerized axial tomography and angiography are of assistance in selected cases. Often, the diagnosis must be established at the time of operation. However, successful biopsy at the time of laparotomy may be difficult to achieve. Pancreatic neoplasms are often surrounded by areas of pancreatitis, and may be difficult to locate. Common duct carcinoma often may be detected by histologic examination of duct scrapings. Even easily accessible duodenal lesions can be difficult to diagnose histologically. Consequently, the surgeon is sometimes forced to perform a radical resection on clinical grounds alone. Resectability is determined at the time of operation. Tumors which have extended outside of the pancreas to involve the portal vein or lymph nodes are generally considered unresectable. Only about 15-20% of carcinomas that originate in the head of the pancreas are resectable. 60-75% of the duodenal ampullary carcinoma will be resectable at the time of surgery and about one half of the common duct tumors will be resectable. Peri-pancreatic lymph nodes will contain metastases in the resected specimen in a significant number of patients: 54% for carcinomas of the head of the pancreas, 20% for ampullary carcinomas, 28% for common duct carcinomas and 32% for duodenal carcinomas. Pancreatoduodenectomy has been followed by the longest survival for patients with carcinoma of the ampulla of Vater. Local excision of the ampulla for carcinoma has been associated with frequent recurrence.

### History

Halsted successfully excised a primary carcinoma of the duodenal papilla February 14, 1898, followed by a cystico-enterostomy three months later. However, this 60-year-old woman succumbed in the autumn of 1898 and it was found that carcinoma had recurred in the head of the pancreas. In 1935, Whipple and his associates reported a two-stage operation for the removal of the duodenum and head of the pancreas and recorded its initial success in the treatment of carcinoma of the ampulla of Vater. By 1941 the procedure was usually employed for extirpation of the head of the pancreas. Operative mor-

talities, since its conception, has ranged from 10 to 20%. Hemorrhage and pancreatic leaks are the most common complications which develop in a post operative period. Biliary leaks, cardiopulmonary failure and sepsis also occur frequently. Five year survival is related to the location of the tumor in the periampullary region. Cancer of the pancreatic head is associated with a five year survival from three to 18%. Carcinoma arising in the papilla has been reported to have a five year survival that ranges from 15 to 40%. In each instance, the absence of lymph node metastasis enhances survival. In summary, the inaccessibility of the periampullary area and the complex anatomic relations of the organs and the blood vessels have an adverse effect upon the diagnosis and treatment of neoplasm arising in this area. The major obstacle to a satisfactory five year survival is lack of a good method for early diagnosis.

**Dr. John Beal:** This patient presents many features associated with peri-ampullary carcinoma. He originally complained of abdominal pain, which occurs in about half of patients with this lesion. There was considerable difficulty in establishing a histologic diagnosis of carcinoma. The surgeon in New Jersey resorted to excision of the ampulla in an effort to obtain a pathologic diagnosis. Specimens were sent to Northwestern Memorial and were reviewed by Dr. Oyasu. Memorial Hospital of New York was also consulted and concurred that this was a carcinoma, probably arising in a villous adenoma. It was then decided that pancreatoduodenectomy was indicated because of the poor results associated with local excision of the ampulla. The presence of residual carcinoma in the specimen removed by the pancreatoduodenectomy underlines the importance of this decision. We are really discussing carcinoma arising in the papilla of Vater which shares many of the characteristics of the head of the pancreas. In both, the onset is usually insidious, and both share the common symptoms of jaundice, pain and weight loss. Often in both, previous operations for treatment of biliary disease have been performed before the appropriate diagnosis is made. Our patient today illustrated this point.

In the series from the Mayo Clinic in 1977, 30% of the patients with carcinoma of the papilla of Vater had undergone surgical procedures for obstructive jaundice before they were treated at the Mayo Clinic. In 1973, Richards and Thompson from the University of Minnesota reported that 12.5% of their patients with carcinoma at the head of the pancreas had cholecystectomy within



six months of treatment in their institutions. There are certain important differences, however. The diagnosis of ampullary carcinoma occasionally may be suspected by the detection of occult blood in the stool of a jaundiced patient. Filling defects in the ampullary lesion on upper gastrointestinal X-rays have been recorded in approximately 40% of patients with ampullary carcinomas, as was the case in this patient. The reverse figure of Frostberg was seen in only one of 152 patients with carcinoma of the head of the pancreas in the University of Minnesota series. The most important differences, however, are related to the rate of resection and prognosis. In the Mayo Clinic series, carcinoma of the papilla of Vater had the resection rate of 96%. Others have reported resectability from 75 to 85%. As Dr. Michelotti stated, this is in marked contrast to the resectability rate of carcinoma at the head of the pancreas which is approximately 15%. It is clear that resection carries a far better prognosis for carcinoma of the ampulla. Occasional patients have had prolonged survival by simple excision of the ampulla but the majority have not fared well. The operative

mortality for pancreatoduodenectomy for carcinoma of the papilla of Vater is lower than it is for carcinoma of the pancreas, and is related to the nature of the disease and the location of the lesion. Dr. Michelotti mentioned that the survival rate is better for papillary carcinoma rising in the papilla, in comparison to infiltrative lesions. The survival rates have been recorded from 24 to 50% for this lesion. The prognosis is also better in the absence of lymph node metastases, as illustrated by this patient. Neither the level of bilirubin nor the presence of pain correlates with the prognosis in ampullary carcinoma. ◀

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## Pulse

(Continued from page 86)

Is the necessary equipment available in your area? CPR is a very expensive program. The equipment, including Resusci Anne, Resusci Baby and Anatomic Anne, costs anywhere from \$195.00 basic price to \$525.00 per item. Perhaps more of our groups can follow Peoria's lead and purchase a Resusci Anne for their own programs and/or future donation to the Heart Association. Lack of equipment directly influences scheduling of classes in many areas. Some of our Illinois classes must be scheduled four to six weeks in advance. Equipment is hard to get and repairs are costly. Perhaps the schools would need to purchase their own equipment, particularly in our larger metropolitan areas. The Heart Association just does not have enough to go around. Certified instructors are desperately needed also. Could school districts be urged to budget sums of money for CPR Instructor's Courses for the teachers?

CPR training is now available in our Illinois Medical Schools. Efforts are being made to train

our physicians in basic CPR. Many local medical societies have urged their members to become certified and have sponsored classes for physicians and the public. The CPR program is an ideal project for cooperation among local medical societies, hospitals and local heart associations.

For an up-date on CPR, the Heart Center of the Baylor College of Medicine will host a conference on Citizen CPR at the Shamrock Hilton, Houston Texas, from April 30-May 2, 1980. The conference will focus on the training, testing, retention, and implementation of community based citizen cardio-pulmonary resuscitation training programs. Interested professionals, paramedics and researchers are asked to send in their original research. This conference is sponsored by Baylor, and co sponsored by the ACT Foundation, the Junior League of Houston, the American College of Emergency Medicine, the American College of Surgeons, and The American Medical Association.

For further information on CPR programs and auxiliary involvement, contact Mrs. Robert Richardson, Peoria, Illinois Health Education chairman, or Mrs. Gamil Arida, Joliet, Illinois second vice president. ◀

# Illinois Housestaff News

## Washington Briefs

BY LINDA HUGHEY HOLT, M.D./CHICAGO\*

### *Labor Relations Act for Housestaff Defeated*

On November 28, HR 2222, the congressional legislative proposal which would have secured collective bargaining rights for housestaff under the National Labor Relations Act, was defeated. The large margin of 167-227 was a surprise to many, as the measure had received bipartisan support from the Education and Labor Committee. Rep. John Erlenborn (R-Ill.) was a vocal opponent of the bill.

The defeat of HR 2222, which had been supported by the AMA, marks a defeat in residents' battle to be considered as professional employees. Again, residents seem to be receiving the worst of both worlds—taxation as employees without the benefits normally afforded to employee groups.

### *NHSC Deferments Extended*

A rider on the "Nurse Training Amendments of 1979" (PL 96-76, S 230) corrects a problem which has been distressing residents with National Health Service Corps obligations. Under Title II of the act, physicians and dentists who have received NHSC scholarships may defer service obligations for three years, or longer periods of time if authorized by the Secretary. In the past, residents have often been pulled out of residency programs to fulfill their service obligations—a rather ridiculous move on the part of the NHSC since fully trained physicians are much more valuable to the Public Health Service than are residents fresh out of their internships! The new law should allow residents in three-year residencies to complete their training, and the intent of the possible extension is to allow residents in longer basic training programs (surgery, ob/gyn, etc.) to complete residency training before being pulled into the NHSC.

### *Military Special Pay System Undergoes Reform*

An issue with which the RPS has been actively involved was in part resolved by the passage of HR 5235 by the House of Representatives (pending Senate passage) by a 377-10 vote. The bill would increase the special pay for physicians, dentists and optometrists in military service. Of

key interest to residents is that the new special pay system would *not* depend on the obligated status of a physician. In the past, physicians with military obligations often were not eligible for variable incentive pay and earned much less than their physician colleagues in the service for the same work.

### *AMA-RPS Interim Meeting Report*

Nine Illinois residents represented the Illinois RPS at the 1979 Interim AMA meeting in Honolulu, Hawaii. Residents attending the meeting were: Scott Carl, Carle Clinic in Champaign-Urbana; Ira Friedlander, Ann Nunnally, and Linda Holt of the University of Chicago; Barry LeCompte and Bill Golden of Rush-Pres. St. Luke's; David Olive, Kimberly Johnson, and Larry Gratkins of Northwestern University. The RPS Assembly heard reports on a number of issues of interest to residents; a report on the nuclear crisis is summarized below and future reports will be covered in the coming months.

### *New RPS Chairman-Elect Position Filled*

Marie G. Kuffner of Houston, Texas, was elected by the RPS House of Representatives at the Interim Meeting to the new position of RPS Chairman-Elect. In July, Dr. Kuffner will assume the post of RPS Chairman.

Dr. Kuffner attended the University of Texas Medical School and received her M.D. in 1976. She is now a resident in anesthesiology at the University of Texas. She has served as RPS Delegate from Texas for the past two years and currently sits on the AMA Council on Scientific Affairs. As the first woman chairman of the RPS, Dr. Kuffner promises to be a highly visible national representative of residents.

### *Governing Council Reports on Nuclear Radiation Education*

As part of a charge from the 1979 RPS Assembly, the Governing Council of the RPS has assembled a list of publications concerning nuclear radiation which should be of value to anyone interested in the issue. The National Council on Radiation Protection (NCRP) has

\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.



published a number of reports which are available to the public:

- NCRP Report #37, "Precautions in the Management of Patients who have received Therapeutic Amounts of Radionuclides."
- NCRP Report #40, "Protection Against Radiation from Brachytherapy Sources."
- NCRP Report #42, "Radiological Factors Affecting Decision-Making in a Nuclear Attack."
- NCRP Report #48, "Radiation Protection for Medical and Allied Health Personnel."
- NCRP Report #59, "Operational Radiation Safety Program."
- NCRP Report #61, "Radiation Safety Training Criteria for Industrial Radiography."

The above pamphlets can be obtained from NCRP Publications, P.O. Box 30175, Washington, D.C. 20014. Also recommended in the report is "An Epidemiologist Takes a Look at Radiation Risks" by Dr. Alice Stewart, DHEW, FDA, Bureau of Radiological Health, Rockville, Maryland 20852, Order N. (FDA) 73-8024-

BHRH/DBE 73-2.

With the ongoing energy crisis and the contribution of medical wastes to the radioactive refuse problem, an educated knowledge of the problems of nuclear radiation is becoming increasingly important for physicians. ◀

#### A Reminder

The recent experience of some physicians who encountered difficulty in obtaining Illinois licensure because of inadequate documentation of their residency training prompts this note. Residents are well advised to check with their individual DME's and verify that participation in the residency program has been appropriately reported to the Illinois Department of Registration and Education. ▶

#### Future ISMS-RPS Meeting Dates

Meetings generally start at 6:30 p.m. at the ISMS offices, 55 E. Monroe, Suite 3510. A buffet supper leads into the business meeting, and visitors are welcome. Please contact the ISMS offices for details if you are interested in attending a meeting. RPS meetings are tentatively scheduled as follows: February 28, March 27, April 24, May 22, June 29 and July 24.

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** Wanted—American-trained family physician to join established family physician in active practice. Guaranteed salary and excellent benefits. Eventual partnership. Robert N. Arrol, M.D., 126 South Locust, Arcola 61910 or 217-268-4444 or 217-268-4404. (4)

**AURORA:** Population 80,000. Opening in 40 man multi-specialty group—located 45 miles from downtown Chicago. Complete office and ancillary services available. Starting salary and benefits with stockholder status, two years. Contact Leonard E. Snyder, 1870 W. Galena Blvd., Aurora, 60506. (312) 859-6700. (3)

**CHICAGO AREA SUBURBS:** Western Cook, DuPage Counties, including Oak Brook, Downers Grove, Wheaton, Lombard, LaGrange, Palos Hills. Opening in new and established multi-specialty medical groups. Complete office facilities with nearby hospital affiliations. Various practice and financial arrangement available. General Practice, Internal Medicine, Family Practice, Obstetrics & Gynecology, Otolaryngology, and Orthopedic Surgery. CONTACT: Jim Gott, Administrator, Suite 205, 6800 S. Main Street, Downers Grove, 60515, 312-852-9400. (12)

**FAIRBURY:** Primary Care and Family Practice Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739 (12)

**FLORA:** Family Practice Physician is needed in Flora, Ill., a stable community in Clay County in south central Illinois. Financing available with a guaranteed income. We have good schools, roads, hospital and neighbors. Contact J. Luff, Administrator, Clay County Hospital Flora, Ill. 62839 (618-662-2131). (1)

**FREEPORT:** Orthopedic Surgeon—Pediatrician—Otolaryngologist—Needed to join 20 physician, multi-specialty clinic. New facilities, fully equipped, adjacent to hospital. Attractive financial arrangement with many fringe benefits. No investment. Contact J. S. Schoenberger, Business Manager, Freeport Clinic, S. C., 1036 West Stephenson Street, Freeport, 61032, AC 815/235-5111. (12)

**GALESBURG:** Population 38,000. Western Illinois, diversified manufacturing and agri-business—stable em-

ployment. Excellent cultural, recreational opportunities, home of Knox and Carl Sandburg Colleges. Practice opportunities in various specialties. Financial assistance available. CONTACT: David D. Fleming, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401, 309/343-8131. (1)

**GALESBURG:** Opening for full time emergency physician in modern trauma center hospital. 12,000 annual visits. Excellent specialty backup. Good salary and flexible schedule. Very nice community, population 36,000. Contact: Fares N. Aris, M.D., St. Mary's Hospital, 3333 N. Seminary St., Galesburg, 61401. (309) 344-2919. (3)

**GARDNER:** Population 2500 (surrounding area 20,000). Opportunity for physician seeking family practice. Very modern medical building available, only one dentist in building (previous physician deceased in May, 79). Very pleasant rural/industrial community only 30 miles from Joliet. Will assist with financing. CONTACT: Chuck Chladek, Depot St., Gardner 60424. Phone (815) 237-2366 or (815) 584-1152. (1)

**GENESE:** Family Practice/Pediatrician/Internist/Orthopedic acutely needed. Ultra modern hospital. Walk in office, complete facilities. Population 7,000, trade area 29,000. 150 miles from Chicago, Interstate 80. 25 miles from Quad-Cities. Nine physicians at present. Contact: Mrs. A. W. Wellstein, 9 Maplewood, Geneseo, 61254 Ph. AC 309-944-2530. (3)

**GENOA:** Population 3500 (surrounding area 15,000). Excellent professional and cultural opportunity for physician seeking independent family practice. Pleasant family community. Located between Chicago, DeKalb, and Rockford. 15 miles from Northern Illinois University. Contact: Irving M. Bush, M.D., 1 Chapman Road, Burlington, 60109. Phone 312-683-2066 or 312-683-2081. (4)

**GREENUP:** Family Practitioner, present physician retiring. Office building, complete with pharmacy and X-ray unit for sale. Factories close, financial assistance available. Good community and practice. Located 190 miles south of Chicago, 20 to 25 miles from Eastern Illinois University and Lakeland Jr. College. Contact: Nicholas J. Beck, M.D., 300 N. Mill St., Greenup, 62428. Phone: 217-923-3311 or 217-923-5134. (1)

**ILLINOIS:** Modern JCAH Mental Health Center seeks a child psychiatrist, psychiatrist and physician. All require Illinois Medical License. Psychiatry positions require Board Certified/Eligible status. Rich environment. Salary commensurate with experience, plus on-call pay. CONTACT: T.R. Adams, 502 Stratton Bldg., Springfield, 62706, or phone (217) 782-4795. (4)



**KEOKUK, IA:** Population 15,000. Opening for family and speciality physicians. Hospital currently undergoing 9.5 million dollar expansion project. Twenty-two physicians at present. Sixty miles from Burlington, IA. Complete office facilities. Financial assistance available. Join our progressive community situated on the banks of the beautiful Mississippi. Contact: Dr. Lynn Walker, Keokuk Area Hospital, P.O. Box 1500, Keokuk, IA 52632, AC 319-524-7150. (1)

**MACOMB:** G.P./F.P. 12 month contract, Illinois License Practice University Health Service outpatient clinic. No OB or surg. Fringes include hospitalization, paid vacation, retirement, etc. Approx. 11,000 students, city 23,000. Competitive negotiable income. EOE/AA. C.E. Hughes, M.D., Director, Beu Health Center, Western Illinois University, Macomb, 61455. (309) 833-2734. (3)

**MOUNT CARMEL:** Growing southern Illinois community of 10,000 located 40 miles north of Evansville, Indiana on the Wabash River. Acute care hospital offering a wide range of services located in the community. Near universities and colleges. Guaranteed income and other financial assistance offered. Contact: William E. Lee, 1418 College Drive, Mount Carmel 62863 (618-262-4121). (1)

**MT. ZION:** Population 4300. A fast growing modern community. Our present Doctor moved to northern part of state. There are two (2) major hospitals in Decatur, eight (8) miles from Mt. Zion. Office facilities available. Unlimited possibilities. CONTACT: Woodrow Gosnell, 1115 N. State Hwy., Mt. Zion, 62549, AC 217-864-2171. (1)

**OBLONG:** Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

**ROCKFORD:** Full-time emergency department physician needed to join fee-for-service group. 35,000 annual visits. 420 bed hospital, 85 miles west of Chicago. Send C.V. or contact Robert C. Porter, M.D., Director, Emergency Department, Swedish American Hospital, 1400 Charles Street, Rockford 61101 (815) 968-4400, Ext. 4105. (4)

**VANDALIA:** Population 5,500. Progressive town in rural Fayette County urgently needs family practice physicians, also internist and pediatrician. Hospital serves county population of 25,000. Seven physicians at present. Sixty miles from St. Louis on I-70. Office facilities available, also financial assistance. CONTACT: John Leckrone, Administrator, Fayette County Hospital, Vandalia. Phone collect 618/283-1231. (1)

**WHITE HALL & ROODHOUSE:** Combined population of 6000 (2 miles apart), 3 physicians. 16,000 persons. 30 bed hospital, built 1978. Complete primary care diagnostic support. Group or solo. Hospital assistance. One hour from major medical complexes and medical schools. Family communities w/sound education and abundant recreation. Contact Larry Bear, White Hall Hospital, 407 N. Main, White Hall 62092. (217-374-2121). (1)

## EKG

(Continued from page 83)

Answers: 1. A. 2. E.

The ECG shows atrial flutter with 2:1 AV block. The flutter waves are best seen in lead 2 at a rate of 300 beats/minute with a ventricular response of 150 beats/minute. This was a recent onset atrial flutter and most of these will convert to sinus rhythm with digitalis alone. Atrial flutter may be seen in patients with chronic obstructive pulmonary disease. In the presence of 2:1 AV block, no comment can be made regarding type I (Wenckebach) or type II (Mobitz) AV block. Our patient was in respiratory failure with hypoxemia and hypercarbia. The patient was intubated and oxygen was administered. Digitalis and diuretics were also used to treat the mild congestive heart failure. He responded to these measures. Direct current cardioversion even at low energy levels will frequently cause conversion of atrial flutter to sinus rhythm. Anesthesia would have been required and this was felt to be dangerous in a patient with respiratory failure. Overdrive atrial pacing has been used successfully to convert atrial flutter to sinus rhythm by presumably breaking up the reentry circuit. Quinidine will depress the atrial flutter but should not be used until the patient is digitalized. Without digitalis to induce some degree of AV block, the quinidine may slow the atrial flutter down to a rate which can be conducted on a 1:1 basis through the AV node. The atropinic effect of quinidine can enhance this 1:1 AV conduction. Fortunately, our patient converted to sinus rhythm with digitalis and improvement in his respiratory status.

# Special Articles

## CME Requirements for License Renewal

In 1975, the legislature amended the Medical Practice Act to require that "the Department [of Registration & Education] based on written recommendations of the [Medical] Examining Committee, shall promulgate mandatory requirements of continuing education . . ." These regulations became effective January 1, 1978.

In response to questions about the meaning of some parts of the regulations, the Medical Examining Committee agreed with some clarifications and interpretations.

This summary of the regulations was prepared by ICCME as a reminder to Illinois physicians, who must renew their licenses before July 1. At the 1979 AMA Annual Meeting, delegates adopted a new definition of continuing medical education. This states that CME "is composed of any education or training which serves to maintain, develop, or increase the knowledge, interpretive and reasoning proficiencies, applicable technical skills, professional performance standards, or ability for interpersonal relationships that a physician uses to provide the service needed by patients or the public."

Licenses are renewed as of July 1 each even-numbered year; for CME purposes, the Department of Registration & Education (R&E) has established a "pre-renewal period" of 24 months ending March 31 of each even-numbered year. 100 hours of CME credit must be earned at any time during the pre-renewal period immediately prior to July 1 of each even-numbered year.

### CATEGORIES OF CREDIT

Rule XI describes 2 categories of CME:

**1. Category 1:** At least 50 hours and up to the full 100 hours:

a) *Category 1-a:* At least 20 hours (up to the full 100 hours) in *formal education programs* sponsored or cosponsored by an organization accredited by the AMA Committee on CME Accreditation (CACME) or the Liaison Committee/CME (LCCME), or the Committee on CME of the American Association of Osteopathic Physicians.

The Medical Examining Committee does not define "formal program"—but accepts the definition of the two major CME accreditation

authorities mentioned above. The ISMS Committee on CME Accreditation defines "formal program" as CME activity offered by an accredited Sponsor that is marked by four characteristics:

(1) A learning need and the audience with that need are identified and described.

(2) Formal Learning Objectives in behavioral form are stated.

(3) Teaching-Learning methods used are appropriate to the need, the audience, and stated Objectives.

(4) A systematic effort is made to evaluate learner achievement of Objectives.

A "formal" program is identical with what AMA defines as a "planned program" for purposes of the AMA Physician's Recognition Award Category 1.

b) *Category 1-b:* Up to 30 hours in (i) teaching medical students or residents including preceptees, and practicing physicians in accredited CME programs (but **not** nurses, medical technicians, or other health workers); *and/or* (ii) participation in evaluation of patient care in a licensed hospital or for a PSRO or similar agency.

Credit for teaching may be claimed on an hour-for-hour basis of actual contact time, regardless of the number of learners involved—provided that it occurs under the sponsorship of an institution accredited for the relevant level (accredited medical school, accredited residency program, or accredited CME Sponsor). Some institutions are accredited for all levels of medical education.

### MEDICAL CARE EVALUATION (OR QUALITY ASSURANCE)

(1) *Hospital.* Credit may be claimed only for participation in the work of hospital "medical audit, patient-care evaluation, utilization review committee or similar committee." The name of the committee is not significant, so long as it focuses on evaluation of quality of patient care.

Credit under this section of Category 1-b is not earned through other quality assurance activities in a hospital—e.g., department meetings devoted to formulation of criteria, or executive committee meetings. The committee must be in a



hospital that is either (a) licensed by the Illinois Department of Public Health or (b) accredited by JCAH.

(2) *PSRO or Foundation*. Category 1-b credit may be claimed for any or all of these activities of a Professional Standards Review Organization or similar body:

(i) Writing criteria for admission, quality of care, and length of stay for various specific diagnoses and/or patient problems; and revising criteria on the basis of evaluation following use.

(ii) Review of a patient record by a physician, in any of these situations: (1) When non-physician co-ordinator is unable to judge validity of admission or length-of-stay and refers case to physician advisor; (2) when such a case comes to attention of consultant advisor because physician advisor and involved attending physician do not agree; (3) when such a case is reviewed by a reconsideration committee because attending physician, physician advisor, and consultant advisor disagree on an issue of medical necessity.

(iii) Time spent by an individual physician, or by a committee of a PSRO, reviewing summary data on patient care from a single hospital or from several hospitals of a defined category, (e.g., particular geographic area, size, kind of services offered) considering whether such summary data points to need for revision of criteria of care for one or more diagnosis(es) and/or patient problem(s).

(iv) Time spent by a PSRO committee or governing Board, in formulating and adopting policies on structure(s) and procedure(s) for review of patient care.

(v) On-site review of appropriateness of in-hospital decisions about medical necessity, by a PSRO physician staff-member or committee.

(vi) Time spent by a PSRO committee or governing board evaluating the quality of medical necessity decisions by individual hospitals.

(vii) Conduct of a medical audit or other assessment of quality of care, by a PSRO staff officer or committee in a hospital when there is need to evaluate criteria and/or standards of medical care studies conducted by the hospital.

(viii) Time spent in reviewing medical care evaluation studies done by a hospital, in order to evaluate performance of a hospital with respect to its use of established criteria and standards of care in judging medical necessity and quality of care.

Credit may **not** be claimed for participation in the management activities of a PSRO or foundation—e.g., budgeting and financial management, development of organizational plans.

*All medical care evaluation credit*: The hospital or PSRO (or foundation) need not be ac-

credited for CME. It must maintain a record of the credit earned by each individual physician in the activities noted, and issue a periodic report to each physician on credit earned.

#### CARRYOVER CREDIT

Note the limit of 30 hours of Category 1-b credit during each two-year pre-renewal period. Credit in excess of 30 hours may be claimed as Category 2 credit.

#### 2. Category 2: Up to 50 hours:

a) *Category 2-a*: (i) Scientific, clinical or educational meetings of recognized *professional organizations*, but not business meetings, and/or (ii) teaching rounds and exercises offered by an accredited *residency* program.

To grant Category 2 credit, a professional organization or residency program need **NOT** be accredited for CME; the Sponsor, however, must maintain a record of the individual physician's "attendance at, or participation in" appropriate sessions and periodically issue a copy of that record to each physician.

b) *Category 2-b*: Informal learning activities—e.g., grand rounds, departmental scientific meetings—in hospitals accredited for CME, when such activities are **not** organized as "formal" programs.

Credit may be earned under Category 2-b only in hospitals accredited for CME. Whether Category 1 or Category 2 credit is granted, the hospital must maintain a record of credit earned and periodically issue a copy to each individual physician.

c) *Category 2-c*: Formal learning experiences including advanced degree programs from agencies **not** accredited for CME but approved by the Department of R&E, in subjects not directly related to clinical medicine that facilitate physician performance; e.g., education, health administration.

d) *Category 2-d*: Papers delivered before recognized specialty societies or published in nationally-recognized medical journals or in a medical book, or exhibits for a medical meeting.

Credit may be claimed for *actual time spent* in preparing a lecture, published paper, chapter in a book, or exhibit. Documentation of credit would be either (a) copy of the program at which the lecture or exhibit was presented, or (b) copy of a published work.

e) *Category 2-e*: Verified self-instruction—individual use of audio-visual material, teaching devices, study of medical literature

—sponsored by a recognized medical college, specialty society, or similar medical institution.

This refers to organized self-study programs. No credit is earned for individual reading of books and journals; the Department assumes that such reading is a natural adjunct to each physician's participation in CME, formal or informal. The key word is "verified"; the self-instruction program must include some device by which the sponsoring agency can verify participation.

Only Category 2 credit may be claimed for self-instruction. The Medical Examining Committee does not denigrate the value of self-instruction; rather, it emphasizes the importance of both (a) Category 2 credit *and* (b) face-to-face interaction with colleagues.

f) *Category 2-f*: Any excess credit hours earned under Category 1-b.

### **Equivalences**

Rule XI provides that any of these achievements or activities during a "pre-renewal" period satisfies Illinois requirements:

a) CME requirements of another state medical licensing authority, provided that 100 hours of CME credit, as defined above, are prescribed for each two-year period.

b) Certification or recertification by a specialty board—if date of certification or recertification falls within the pre-renewal period;

c) CME requirements of a national specialty society—provided that 100 hours of CME credit as defined above are prescribed for each two-year period; or

d) Six months or longer full time in an approved residency program or postresidency fellowship during a pre-renewal period. No partial credit may be claimed. If you complete a residency in June—three months into the next pre-renewal period—you must earn the full 100 hours of CME required for the next license renewal.

### **Measure of Credit, Record Requirements**

One clock hour substantively spent in any of the activities noted under Category 1 and Category 2, above, equals one credit hour for Illinois license renewal purposes.

Ordinarily, R&E does not ask the physician to report CME credit earned at each license renewal. Instead, the license renewal form invites you to check a box, "Yes" or "No," to indicate compliance (or non-compliance).

The Department reserves the right, however, to verify a physician's statement that he/she complies with Rule XI—both his/her individual records and the records of sponsors from which

the credit was earned. For license renewal, the Department may ask a sample of physicians to submit a listing of CME credit earned during the pre-renewal period, along with license renewal. Further, the Department reserves the right to check all CME records for four years following each pre-renewal period.

Accordingly, you should (a) obtain certificates or other record of credit earned for each activity listed under Category 1 and Category 2, above, in which you participate, and (b) keep those records for *two* pre-renewal periods following each biennial license renewal.

Likewise, CME sponsors—all the kinds of agencies noted above under Category 1 and Category 2—must maintain a full record of all CME credit earned and periodically issue a copy of this record to individual physicians. Sponsor records must also be maintained for two pre-renewal periods after the two-year period in which the credit was earned.

### **Newly-Licensed Physicians, Practitioners New to Illinois**

A physician who is licensed in Illinois by examination need NOT comply with these CME requirements for the first renewal of license.

An experienced practitioner who moves into Illinois during a pre-renewal period and obtains a license without examination, must satisfy the full 100-hour CME requirement during that current pre-renewal period to have his Illinois license renewed. CME credit earned before moving into the State satisfies Illinois requirements (provided that it fits the categories and sub-categories of credit described above).

### **Waiver and Extension, Other Provisions**

Should a physician be unable to earn the CME credit prescribed during a pre-renewal period, because of (a) fulltime service in the regular U.S. Armed Forces, or (b) inability to devote sufficient hours to CME because of "illness, incapacity, undue hardship or any other extenuating circumstances," said physician may request a waiver or extension of time. In requesting such exemption, the applicant must present sound evidence of the factors that prevented compliance with the regulations; if desired, he/she may request a hearing before the Medical Examining Committee to argue for waiver or extension.

All information submitted to R&E about CME is deemed strictly confidential. It may be released only upon (a) consent of the individual practitioners, (b) for hearings by R&E or the Medical Disciplinary Board, or (c) upon subpoena from an authorized court or administrative agency. ◀



**ILLINOIS CATEGORY 1 ACCREDITED CME SPONSORS  
AS OF FEBRUARY 1, 1980**

Illinois law requires that 100 hours of continuing medical education (CME) credit be earned during a pre-license renewal period. Regulations stipulate that at least 50 of the 100 hours must be Category 1; the balance of hours may be Category 2. Credit must be earned by each physician during the two year period April 1, 1978 through March 31, 1980. Of the 50 hours Category 1 credit, a minimum of 20 must be part of an approved, formal educational program. The balance may fall into the realm of approved teaching or medical care audit activities.

- |   |   |
|---|---|
| Alexian Brothers Medical Center—Elk Grove Village           | The Methodist Medical Center of Illinois—Peoria   |
| Alfred Adler Institute of Chicago, Inc.                     | Michael Reese Hospital & Medical Center—Chicago   |
| Augustana Hospital—Chicago                                  | Mount Sinai Hospital Medical Center of Chicago    |
| Belleville Hospital Association for CME                     | Northwestern University Medical School—Chicago    |
| (Memorial Hospital, St. Elizabeth Hospital)                 | North Shore Mental Health Association/            |
| Carle Foundation Hospital—Urbana                            | Irene Josselyn Clinic—Northfield                  |
| Central Community Hospital—Chicago                          | Northwest Hospital—Chicago                        |
| Central DuPage Hospital—Winfield                            | Northwest Community Hospital—Arlington Heights    |
| Champaign County Medical Society                            | Norwegian-American Hospital—Chicago               |
| Chicago College of Osteopathic Medicine                     | Oak Forest Hospital                               |
| Chicago Medical Society                                     | Oak Park Hospital                                 |
| Chicago Neurological Society                                | Provident Hospital—Chicago                        |
| Chicago Pediatric Society                                   | Ravenswood Hospital Medical Center—Chicago        |
| Chicago Surgical Society                                    | Resurrection Hospital—Chicago                     |
| Christ Hospital—Oak Lawn                                    | Riveredge Hospital—Forest Park                    |
| Columbus-Cuneo-Cabrini Medical Center—Chicago               | Riverside Hospital—Kankakee                       |
| Community Memorial General Hospital—LaGrange                | Rockford Memorial Hospital                        |
| Cook County Hospital—Chicago                                | Rock Island Franciscan Medical Center             |
| Copley Memorial Hospital—Aurora                             | Roosevelt Memorial Hospital—Chicago               |
| DuPage County Medical Society—Lombard                       | Rush Medical College—Chicago                      |
| Elgin Mental Health Center                                  | Sarah Bush Lincoln Health Center—Mattoon          |
| FAB <sup>3</sup> -CME (Forkosh Memorial, Belmont Community, | Sherman Hospital—Elgin                            |
| Bethesda, Bethany Methodist, Thorek Medical Center)         | Silver Cross Hospital—Joliet                      |
| Chicago   | Skokie Valley Community Hospital—Skokie           |
| Forest Hospital—Des Plaines                                 | South Chicago Community Hospital                  |
| Gottlieb Memorial Hospital—Melrose Park                     | South Shore Hospital—Chicago                      |
| Grant Hospital of Chicago                                   | Southern Illinois Medical Association—Belleville  |
| Henrotin Hospital—Chicago                                   | Southern Illinois University School of Medicine—  |
| Highland Park Hospital                                      | Springfield                                       |
| Hinsdale Sanitarium & Hospital                              | St. Anne's Hospital—Chicago                       |
| Holy Cross Hospital—Chicago                                 | St. Anthony Hospital—Chicago                      |
| Illinois Central Community Hospital—Chicago                 | St. Anthony Hospital—Rockford                     |
| Illinois Council on Continuing Medical Education            | St. Elizabeth's Hospital—Chicago                  |
| Illinois Heart Association                                  | St. Elizabeth Hospital—Danville                   |
| Illinois Hospital Research & Educational Foundation-        | St. Elizabeth Hospital—Granite City               |
| Illinois Hospital Association                               | St. Francis Hospital—Blue Island                  |
| Illinois Masonic Medical Center—Chicago                     | St. Francis Hospital-Medical Center—Peoria        |
| Illinois Society of Allergy and Clinical Immunology         | St. Joseph Hospital—Chicago                       |
| Illinois Society of Ophthalmology and Otolaryngology        | St. Joseph Hospital—Elgin                         |
| Illinois Thoracic Surgical Society                          | St. Mary's Hospital—Kankakee                      |
| Institute for Psychoanalysis—Chicago                        | St. Mary's Hospital—Streator                      |
| Jackson Park Hospital—Chicago                               | St. Mary of Nazareth Hospital—Chicago             |
| Kishwaukee Community Hospital—DeKalb                        | St. Therese Hospital—Waukegan                     |
| Lake Forest Hospital  | SwedishAmerican Hospital—Rockford                 |
| Little Company of Mary Hospital—Evergreen Park              | Swedish Covenant Hospital—Chicago                 |
| Louis A. Weiss Memorial Hospital—Chicago                    | Tinley Park Mental Health Center                  |
| Louise Burg Hospital—Chicago                                | University of Chicago Pritzker School of Medicine |
| Loyola University Stritch School of Medicine—Maywood        | University of Health Sciences/The Chicago Medical |
| Lutheran General Hospital—Park Ridge                        | School  |
| Lutheran Hospital, Moline                                   | University of Illinois College of Medicine        |
| MacNeal Memorial Hospital—Berwyn                            | Victory Memorial Hospital—Waukegan                |
| Martha Washington Hospital—Chicago                          | Westlake Community Hospital—Melrose Park          |
| Mary Thompson Hospital—Chicago                              | West Suburban Hospital—Oak Park                   |
| Memorial Hospital of DuPage County—Elmhurst                 | Woodlawn Hospital—Chicago                         |
| Mercy Hospital & Medical Center—Chicago                     | Wood River Township Hospital                      |

# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603; (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

## MARCH

### Diabetic Crisis

For: all specialties. Dinner/lecture, March 25, 6:00 p.m., Highland Park. Speaker: Arthur Rubenstein, M.D. Sponsor: Highland Park Hospital, 718 Glenview Ave., Highland Park 60035. Reg. deadline: 3/14. Fee: \$10. Reg. limit: 60. Credit: AMA Category 1, 1 hour. Contact: Arnold Goldstein, MD. Phone: 312/432-8000 x 4000.

### Acute Care

### Chest Diseases

#### Respiratory Failure

For: GP's, Fulltime Specialty. Lecture, March 12, 1:30 p.m., Chicago. Speaker: Charles Rice, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Chicago 60637. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

### Counseling

#### Grief Counseling: A Conference for Health Care Professionals

For: health care professionals. Lecture, March 14-15, Chicago. Sponsor: University of Chicago Center for Continuing Education, 1307 E. 60th St., Chicago 60637. Fee: \$125. Reg. limit: 100. Credit: AMA Category 1, 13 hours. Contact: Elsie Newton. Phone: 312/753-3185.

### Family Medicine

#### Clinical Medicine Update

For: FP's, GP's. Lecture, March 17 (5 days), Chicago. Speaker: Sheldon Woldstein, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Boker, MD. Phone: 312/733-2800.

### Internal Medicine

#### Internal Medicine Review

For: MD's. Seminar, Monday evenings, March 3-May 19, 7:00 p.m., St. Louis, MO. Sponsor: Office of CME, Washington University School of Medicine, Box 8036, 660 S. Euclid, St. Louis, MO 63110. Fee: \$150. Reg. limit: 200. Credit: AMA Category 1, 36 hours. Contact: Loretta Gioaceto. Phone: 314/367-9673.

### Internal Medicine/Surgery

#### Renal Transplants—Costs & Quality of Life vs. Dialysis

For: MD's. Lecture, March 19, Good Samaritan Hospital, Downers Grove. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Lombard 60148. Fee: none. Reg. limit: none. Credit: AMA Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Lillian Widmer. Phone: 312/495-4050.

### Neurology

#### Scientific Aspects of Neurology

For: Neurologists, Psychiatrists, Neurosurgeons. Workshop, March 19-22, Continental Plaza Hotel, Chicago. Sponsor: University Office of Continuing Education, 600 S. Paulina, Chicago 60612. Cosponsors: Rush-Pres.-St. Luke's Medical Center. Reg. deadline: March 12. Fee: \$300. Credit: AMA Category 1, 28 1/2 hours. Contact: Joseph Vaol. Phone: 312/942-7119.

## Obstetrics & Gynecology

### International Symposium on Uterine Placental Blood Flow

For: Obstetricians, Gynecologists. Symposium, March 23-25, University of Chicago Center for Continuing Education. Sponsor: Chicago Heart Association, 20 N. Wacker Drive, Rm. 1240, Chicago 60606. Credit: AMA Category 1, 13 hours; ACOB, 13 cognates. Contact: Elsie Newton. Phone: 312/753-3185.

### Pediatrics

#### Downstate Illinois Pediatric Society Meeting

For: MD's. Symposium, March 29-30, Springfield. Sponsor: Downstate Illinois Pediatric Society, 320 E. Armstrong, Peoria 61603. Cosponsor: SIU School of Medicine. Reg. limit: none. Fee: yes. Credit: AMA Category 1, 7 hours. Contact: Thomas Smith. Phone: 309/672-6341.

### Psychiatry

#### Comprehensive Psychiatry Review

For: candidates for Part I, Board Examination. Lecture, March 3-8, Chicago. Sponsor: University of Chicago Departments of Psychiatry and Neurology, 950 E. 59th St., Chicago 60637. Fee: yes. Reg. limit: 150. Credit: AMA Category 1, 42 hours. Contact: John Crayton, MD. Phone: 312/947-6415.

### Psychiatry

#### Specific Issues of Clinical Diagnosis and Treatment

For: Psychiatrists. Lecture, March 4 & 18, Chicago. Sponsor: Institute for Psychoanalysis, 180 N. Michigan, Chicago 60601. Fee: \$50. Reg. limit: 45. Credit: AMA Category 1. Contact: Eva Sondberg. Phone: 312/726-6300.

### Psychiatry

#### Geriatric Psychiatry

For: Psychiatrists. Lecture, March 21-22, Chicago. Sponsor: University of Chicago Department of Psychiatry, 950 E. 59th St., Chicago 60637. Fee: \$200; \$125, residents. Reg. limit: 150. Credit: AMA Category 1, 13 hours. Contact: Allen Kodish, MD or Robert Kohn, PhD. Phone: 312/947-6446.

### Psychiatry

#### Psychiatry Board Preparation, Part II

For: candidates for Part II, Board Examination. Lecture/workshop, March 30-April 1, Chicago. Sponsor: University of Chicago Departments of Psychiatry and Neurology, 950 E. 59th St., Chicago 60637. Fee: \$250. Reg. limit: 75. Credit: AMA Category 1, 20 hours. Contact: John Crayton, MD. Phone: 312/947-6415.

### Radiology & Lab

#### Radiology & Lab

For: MD's. Lecture, Saturdays, 9:00 a.m., Chicago. Sponsor: St. Anne's Hospital, 4950 W. Thomas, Chicago 60651. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Francis Banich, MD. Phone: 312/378-7100 x 106.

### Surgery

#### Advances in Surgery

For: General & Specializing Surgeons. Lecture, March 24 (5 days), Chicago. Speaker: Robert Boker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 100. Credit: AMA Category 1, 40 hours. Contact: Robert Boker, M.D. Phone: 312/733-2800.

## APRIL

### Cardiac Rehabilitation

#### Total Cardiac Rehabilitation Workshop

For: MD's, RN's, Physical Therapists. Workshop, Week 1, April 7-11 (lecture), Week 2, April 14-18 Optional (staff participation), La Crosse, WI. Sponsor: La Crosse Exercise Program—Workshop Unit, Mitchell Hall, University of WI, La Crosse 54601. Fee: \$350, week 1; \$200, week 2. Reg. limit: 50. Credit: various. Contact: Philip Wilson. Phone: 608/785-8686.

### Family Medicine

#### Diseases of the Liver: Update on Practical Diagnosis and Management

For: MD's. Lecture, April 12, 8:00 a.m., Chicago. Sponsor: Liver Study Unit, Dept. of Medicine, University of Chicago, Center for Continuing Education, 1307 E. 60th St., Chicago 60637. Fee: \$90; \$55, residents. Reg. limit: 150. Credit: AMA Category 1, 7 hours; AAFP Elective, 7 hours. Contact: Elsie Newton. Phone: 312/753-3185.

### Family Medicine

#### Annual Postgraduate Seminar

For: FP's. Seminar, April 18-22, Holiday Inn Mart Plaza, Chicago. Sponsor: Illinois Academy of Family Physicians, 1200 Harger Rd., Suite 405, Oak Brook 60521. Fee: members, n/a; non-member, \$25. Credit: AMA Category 1; AAFP Prescribed. Contact: H. Morchmont-Robinson, MD. Phone: 312/325-8502.

### Gynecologic Oncology

#### Current Concepts in Gynecologic Oncology

For: Obstetricians, Gynecologists. Lecture, April 11-12, Chicago. Sponsor: Department of Obstetrics and Gynecology, University of Chicago, The Chicago Lying-In Hospital, 950 E. 59th St., Chicago 60637. Credit: AMA Category 1, 11 hours; 11 cognates, ACOG. Contact: Elsie Newton. Phone: 312/753-3185.

## CASSETTE RESOURCE CENTER

One-hour videocassette programs available to supplement other CME programs; most programs acceptable for credit by the AMA and AAFP; available on a rental or purchase basis to physicians/hospitals. Complete information available from: The Network for Continuing Medical Education, 15 Columbus Circle, New York, New York 10023.



## Immunohematology

**Blood Transfusions, Its Hazards and Liabilities**  
For: MD's, DO's, RN's, MT's. Seminar, April 17, 7:00 p.m., Maline Public Hospital, Maline. Speaker: Joseph Bove, MD. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust St., Davenport, IA 52803. Reg. limit: 200. Fee: \$15. Aux. Med., \$4. Credit: AMA Category 1, 2 hours. Contact: Patricia Harrod. Phone: 319/359-5401.

## Internal & Pulmonary Medicine

**Specialty Review Course in Pulmonary Disease**  
For: Pulmonary Specialists, Lecture, April 28 (5 days), Chicago. Speaker: John Sharp, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: \$150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Medicine

### Cardiovascular

For: MD's. Symposium, April 2, 8:00 a.m., Chester. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Orthopaedic Problems

For: MD's. Symposium, April 17, 1:00 p.m., Litchfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Nuclear Medicine, Cardiology

**Non-Invasive Regional Wall Motion Evaluation Using Dynamic Radionuclide Cardiac Studies**

For: Nuclear medicine physicians, Cardiologists, Radiologists, Symposium, April 18-19, Chicago Illinois Union, Chicago. Speaker: Dan Pavel, MD. Sponsor: University of Illinois Medical Center, Dept. of Radiology, Section on Nuclear Medicine, c/o Office of Continuing Education Services, 1853 W. Polk St., Rm. 144, Chicago 60612. Reg. deadline: 4/5. Fee: \$100; \$50, residents. Credit: AMA Category 1, 9 hours. Contact: Sue Korienek. Phone: 312/996-8025.

## Oncology

**Hormone Manipulation in the Therapy of Human Malignant Disease**

For: MD's. April 15-16, The Drake Hotel, Chicago. Speaker: Jules Harris, MD. Sponsor: Rush Medical College, University Office of Continuing Education, 600 S. Paulina St., Chicago 60612. Fee: \$100. Reg. limit: 125. Credit: AMA Category 1, 14 hours. Contact: Jean Davis. Phone: 312/942-7095.

## Ophthalmology/Otolaryngology

**Spring Meeting Illinois Society of Ophthalmology & Otolaryngology**

For: Ophthalmologists, Otolaryngologists. Lecture, April 18-20, Marriott O'Hare, Chicago. Sponsor: Illinois Society of Ophthalmology & Otolaryngology, 101 West North St., Danville 61832. Fee: \$50. Reg. limit: none. Credit: AMA Category 1, 7 hours. Contact: A. Reese Matton, MD. Phone: 217/446-6410.

## Radiology/Orthopedics

**Seminar/Workshop on Arthrography and Skeletal Trauma**

For: Radiologists, Orthopedic Surgeons, GP's, FP's, Emergency Room Physicians. Lecture/workshops, April 28-30, Sheraton Inn, Madison, WI. Sponsor: University of WI—Extension, Dept. of CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. Cosponsor: University of WI—Madison, School of Medicine, Dept. of Radiology. Fee \$250, seminars & workshops; \$200, seminars only. Credit: AMA Category 1, 21 hours; ACR, applied for. Contact: Sarah Aslakson. Phone: 608/263-2856.

## Respiratory Care

**Update: 1980 Oxygen Delivery and the Critical Care Patient**

For: MD's, RN's, therapists. Symposium, April 23, Chicago. Speaker: James McNally. Sponsor: Mt. Sinai Hospital Medical Center, 15th St. & California Ave., Chicago 60608. Reg. deadline: 4/9. Fee: \$35. Reg. limit: 200. Credit: AMA Category 1, 5 hours. Contact: S. Jones. Phone: 312/542-2563.

## Rheumatology

### A Seminar on Rheumatic Disease

For: GP's. Symposium, April 23, 8:00 a.m., Waukegan. Sponsor: Victory Memorial Hospital, 1324 N. Sheridan Rd., Waukegan 60085. Fee: \$5. Reg. limit: 110. Credit: AMA Category 1, 5 hours; AAEP Elective, 5 hours. Contact: Frank Magliery. Phone: 312/688-4001.

## Urology

### Specialty Review Course in Urology

For: Urologists. Lecture, April 7 (5 days), Chicago. Speaker: Irving Bush, MD; Thomas John, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$275. Reg. limit: 150. Credit: AMA Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## MAY

## Cardiac Surgery

### Coronary Artery Bypass Surgery

For: GP's, full-time specialty. Lecture, May 14, 9:30 a.m., Chicago. Speaker: Constantine Anastopoulos, MD. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Chicago 60637 (Culver Hall 405). Reg. limit: none. Credit: AMA Category 1, 6 hours; AAEP Elective, 6 hours. Contact: Elaine Ehrman. Phone: 312/947-5777.

## Clinical Cardiology II

### Mitral Valve Disease in Adults

For: MD's. Symposium, May 23, 10:45 a.m., Oak Park. Speaker: William Millman, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## Coronary Artery Disease

### Coronary Artery Disease in the '80's—Clinical Dilemma?

For: MD's, RN's. Lecture, May 8-9, Springfield. Sponsor: Illinois Heart Association, 1181 N. Dirksen Pkwy., Box 2666, Springfield 62708. Cosponsors: American Heart Association Council on Clinical Cardiology, SIU School of Medicine. Reg. deadline: 5/5. Reg. limit: 300. Credit: AMA Category 1, 13 hours; AAEP Elective, 13 hours. Contact: A. Paul Naney, MD. Phone: 217/525-1350.

## Medicine

### Medical and Surgical Aspects of Arthritis

For: MD's. Symposium, May 15, 1:00 p.m., Jacksonville. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Hypertensive Update

For: MD's. Symposium, May 22, 7:00 p.m., Benton. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Communicable Diseases in Children Update

For: MD's. Symposium, May 14, 9:00 a.m., East St. Louis. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: AMA Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Thyroid Disorders

For: MD's. Symposium, May 8, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, P. O. Box 3926, Springfield 62708. Reg. limit: none. Fee: \$30. Credit: AMA Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Pediatrics

### Renal Failure in Children

For: MD's. Symposium, May 2, 10:45 a.m., Oak Park. Speaker: Robert Muehrcke, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## Pediatrics

### Pediatric Endocrinology

For: MD's. Symposium, May 9, 10:45 a.m., Oak Park. Speaker: Marion Brooks, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## Pediatrics

### Mitral Disease in Children

For: MD's. Symposium, May 16, 10:45 a.m., Oak Park. Speaker: Barbara Santucci, MD. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Credit: AMA Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## Primary Care

### EKG Interpretation and Arrhythmia Management

For: GP's, Internists. Lectures/workshops, May 9-11, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. Fee: \$215. Reg. limit: 60. Credit: AMA Category 1, 15 hours; AAEP Elective, 15 hours; AOA, 15 hours; ACEP, 15 hours. Contact: Stephen Mottingly. Phone: 800/525-8646 x 237.

## Psychiatry

### Francis J. Gerty Lecture Series

For: MD's, therapists. Lecture, May 21, 1:00 p.m., Forest Park. Speaker: Joseph Zinker, PhD. Sponsor: Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: AMA Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000 x 305.

## Vascular Surgery

### Vascular Surgery Symposium

For: MD's. Symposium, May 2-3, Madison, WI. Sponsor: University of WI—Extension and University of WI—Madison, c/o 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. Fee: \$145. Reg. limit: 150. Credit: AMA Category 1, 12 hours; AAEP Elective, 12 hours. Contact: Sarah Aslakson. Phone: 608/263-2856.

## Two Unusual CME Planning Aids . . .

. . . can help you plan better programs, whether in hospital or Medical Society:

"Case Discussion & Problem Solving," details a tested method for using case discussion that generates enthusiastic interest among MD's.

"Planning CME Programs that Fit Staff Needs: Patient Problem Inventory," describes how to gather data on the kind of patient problems that a given group of physicians (a) see often and (b) feel a need to learn more about. Proven in use, this method taps physicians' basic motivation to continue learning.

Both are FREE to Illinois physicians and CME planners, upon request. To others, a charge is necessary to cover cost of printing, postage, and mailing: "Case Discussion," \$2.00; "Patient Problem Inventory," \$2.00.

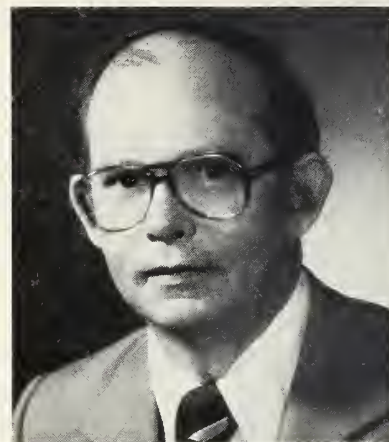
For your copy of either (or both), write or call:

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, Illinois 60603  
(312) 236-6110

# President's Page

*"For every problem there is a solution and it is simple, easy and wrong."*

Abraham Lincoln



## Simple, Easy . . . and Maybe Wrong

Issues and conflicts confront the medical community constantly. Some are patently specious, others are extremely significant. Undeniably, the Individual Practice Association (IPA) issue merits the "significant" label.

The initial tremors generated by the IPA issue surfaced at the House of Delegates session in November. Following debate that must be characterized as highly-charged and exhaustive, the House authorized the Board of Trustees to continue mapping plans to develop a health insurance carrier designed to meet the specialized needs of IPAs.

Data developed since that session has failed to crystalize the broad IPA picture. Simply stated, the situation remains perplexing. There seems to be no clear cut approach that is void of potential difficulties and carries a guarantee of success. Considerable discussion and study has raised many questions, but provided few concrete answers.

A commitment to proceed with development of a carrier or a decision to back away from that concept must be carefully weighed. Hopefully, further deliberations by the House in April will dictate a course of action that is tenable for us today and also will stand the test of history.

IPAs may be a tool that enables us to ensure quality care that is cost effective . . . and impede—possibly even checkmate—government intrusion into health care. The concept of Illinois blanketed by local IPAs run by local physicians is exciting and challenging. Despite the positiveness, IPAs also have negative possibilities. They may open the door that allows individuals and groups who do not understand medical practice to seize control of the health care system.

Now is the time for analysis. In a few months, we must make a decision on how the State Medical Society and physicians will relate to IPAs both regionally and statewide. There are no simple or easy solutions. ◀

A handwritten signature in cursive script, reading "John Seward".

P. John Seward, M.D., President



# Doctor's News

**HUMANITIES SEMINARS ANNOUNCED**—The National Endowment for the Humanities has announced 1980 seminars for physicians, nurses and other health care professionals. The program provides a month's full-time study in seminars directed by distinguished American scholars at various locations. Three seminars open only to health care professionals will address historical, ethical and legal issues surrounding human genetics (July 7-August 1), political dimensions of health care policy (June 30-July 25) and the physician in society with a perspective on antecedents to contemporary health issues (July 9-August 6). Five additional inter-professional seminars are scheduled for the period between June 30 and August 29.

From 12-15 persons attend each seminar tuition free, receiving a stipend of \$1200 plus travel reimbursement. The application deadline is April 14, 1980. Further information may be obtained by writing: Professions Program, Fellowships Division MS-101, National Endowment for the Humanities, Washington, D.C. 20506.

**ANNUAL RURAL HEALTH CONFERENCE ANNOUNCED**—The American Medical Association has announced the 33rd National Conference on Rural Health will be held April 17-18, 1980, at the Sheraton-Boston Hotel. Over 30 workshops, CME courses and general sessions will be available to physicians, who may earn up to 15 Category 1 CME credits for attending the conference. Courses for physicians treating rural populations will include primary management of trauma in agriculture, poisonings, zoonosis, replantation microsurgery, sports medicine for rural schools and nutritional assessment and management. Further information and reservations may be obtained by writing the AMA Department of Meeting Services, 535 N. Dearborn St., Chicago IL 60610.

**OPHTHALMOLOGY EDUCATION**—In developing recommendations for its members on materials to use in ophthalmologists' offices or related health care facilities, the American Academy of Ophthalmology is seeking copies of public and patient education materials that relate to eye care. The Academy is expanding efforts to educate the public and collecting materials in order to avoid duplicating available information. Physicians are asked to forward samples of brochures, policy statements, press releases, newspaper and magazine clippings, audio visual and other materials to: William C. Felch, Jr., Director of Communications, American Academy of Ophthalmology, 1833 Fillmore Street, Post Office Box 7424, San Francisco CA 94120.

**IPS ANNUAL DINNER ANNOUNCED**—The Illinois Psychiatric Society will hold its annual dinner March 19, 1980, at the Chicago Drake Hotel. Guest speaker for the dinner is Frank M. Ochberg, M.D., director of the Michigan Department of Mental Health, who will present a talk entitled "The Victims." Dr. Ochberg, a nationally reknowned expert in violence and terrorism, will discuss hostage victimization.

Reservations for the dinner may be obtained at a cost of \$21.50 (\$16.50, residents) by writing the Illinois Psychiatric Society, 55 E. Monroe, Suite 3510, Chicago IL 60603.

**"SPINAL CORD INJURY: A GUIDE FOR CARE,"** has been published in its most recent edition by the New York Regional Spinal Cord Injury Center, New York University Medical Center, Institute of Rehabilitation Medicine, 400 E. 34th St., New York NY 10016. The Guide is a 92-page booklet designed for patient self-education in health care after experiencing spinal cord injuries. Although addressed to patients at that medical center, the information could be of interest to any spinal cord injured patient.

**PHYSICIANS IN THE NEWS**—**Silvio Aladjem, M.D.**, Maywood, professor and chairman of the Loyola University Medical Center department of obstetrics and gynecology and **Craig Anderson, M.D.**, director of newborn medicine at Loyola are principal investigators in a five year project of the National Institute of Health entitled "The efficacy of prophylactic penicillin in controlling Group B streptococcal (GBS) sepsis in the newborn." Doctor Aladjem was also recently elected president of the International Association of Maternal and Neonatal Health . . . **Milton Vainder, M.D.**, Glencoe, attending physician in internal medicine at St. Francis Hospital, Evanston, was recently elected president of the national alumni association of the Chicago Medical School. Dr. Vainder was a founder of the CMS alumni association, and has participated actively over the past 20 years.

**Herbert E. Natof, M.D.**, Highland Park, has been named vice chairman, Professional and Technical Advisory Committee, JCAH accreditation program for ambulatory care. Dr. Natof will represent the AMA in that capacity . . .

**Sandra Olson, M.D.**, Chicago, was recently appointed to the AMA Ad Hoc Committee on Woman Physicians in Organized Medicine. Dr. Olson is also a member of the ISMS Public Affairs Committee . . . **Lee Gladstone, M.D.**, Chicago, was recently named American Hospital Association Board of Trustees representative to the National Advisory Committee on Alcohol Abuse and Alcoholism.



**R. M. Adelman, D.D.S., M.D., J.D.**, vice president for medical affairs and director of medical education and Sister Maryann Regensburger, S.Sp.S., president and chief executive officer at St. Therese Hospital in Waukegan, recently received the Abbott Achievement Award, commemorating the 50th anniversary of St. Therese Hospital and 25 years service by the chief executive officer. Shown in photo at left (L-R) are Dr. Adelman, Sister Maryann and Ron Mulcahy, Abbott Laboratories' District Sales Manager, who presented the award.

**QUALITY ASSURANCE SEMINAR ANNOUNCED**—The Illinois Medical Records Association will sponsor a two-day program designed to assist members of hospital quality teams, including physicians and administrative personnel, in complying with the new JCAH Quality Assurance Standard. Scheduled for March 13-14, 1980, at the Henrici Clock Tower Inn in Rockford, Illinois, the program will address means to implement hospital programs for quality assurance on day one, and focus on relevant activity in medical records on day two. Further information may be obtained through individual Illinois hospital administrators.

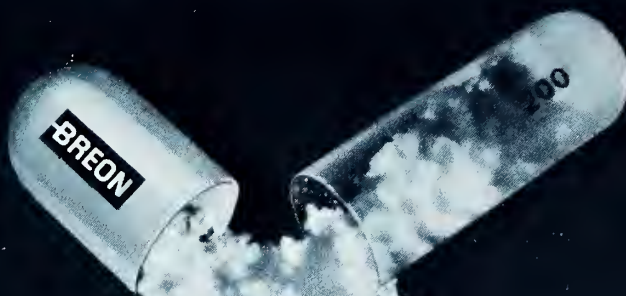
**CIVIL LAW AND THE PSYCHIATRIST**—is the title of a one and a half day symposium sponsored by the Section of Psychiatry and the Law, Department of Psychiatry, Rush Medical College. Scheduled for March 14-15, 1980, at the Continental Plaza Hotel in Chicago, the symposium will consider a wide cross-section of issues through presentations by medical and legal experts. Twelve hours of Category 1 CME credit are available to participants. Registration is \$150 for physicians and attorneys, and \$125 for Rush Network Physicians and residents. Further information may be obtained by writing the University Office of Continuing Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Academic Facility, Chicago IL 60612.

#### **GREAT PLAINS SPORTS MEDICINE & HEALTH FITNESS CONFERENCE ANNOUNCED**

—The Great Plains Sports Medicine Foundation, in co-sponsorship with the St. Francis Hospital-Medical Center in Peoria, will hold their tenth annual sports medicine conference March 28-29 at the Holiday Inn-Brandywine in Peoria. Further information may be obtained by writing Jeff Sunderline, Program Director, 624 N.E. Glen Oak, Peoria, IL 61603; (309) 672-2386.



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<sup>1</sup> Tinkelman, D.G., Carroli, M.S., Vanderpool, G., Jones, M.: The bioavailability of theophylline in elixir and micro-pulverized forms. *Medical Challenge* 10 24-26, 1978.

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**CONTRAINDICATIONS:** Hypersensitivity to any of its components.

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Status asthmaticus is a medical emergency. Addition of corticosteroids and other medications to bronchodilator therapy may be required.

Serum theophylline levels should be monitored at appropriate intervals for dosage adjustment. High serum levels of theophylline and resultant toxicity may occur with conventional doses in patients with decreased theophylline clearance as found with cardiac failure, liver disease, chronic obstructive pulmonary disease, and in geriatric patients.

Early signs of theophylline toxicity, such as nausea and restlessness may not occur prior to convulsions or ventricular arrhythmias. Pre-existing

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**Usage in Pregnancy:** Theophylline safety in pregnancy has not been established. Use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

**PRECAUTIONS:** Smokers may require larger doses of theophylline because of a shorter half-life in these patients.

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Caution should be observed in patients with cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, peptic ulcer, and in the elderly and neonates. Patients with congestive heart failure in particular may have markedly prolonged serum half-lives of theophylline.

**ADVERSE REACTIONS:** Most adverse reactions to theophylline are seen with serum levels exceeding the therapeutic range. **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea. **CNS:** headache, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions. **Cardiovascular:** palpitations, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias which may be life-threatening. **Respiratory:** tachypnea. **Renal:** diuresis, albuminuria. **Other:** hyperglycemia, inappropriate ADH

secretion.

**Drug Interactions:** Toxic synergism with ephedrine and other sympathomimetic bronchodilators may occur.

**OVERDOSAGE Treatment:**

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# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

Dear Colleague:

I am sometimes amazed that the very members of our profession who bemoan the ever-increasing government intrusion into our ability to practice medicine are the same physicians who don't join IMPAC and constantly wonder what possible good IMPAC could do them. Each time a "bad bill" passes, I wonder whether it might have been defeated if these same physicians were involved in the political process. Each time a "bad bill" is defeated, I wonder if the task might have been easier if just one more physician had contacted his legislator regularly and had developed a personal one-to-one relationship.

I thought you might be interested in just a few bills which were defeated during the last session of the legislature -- and this is a limited list.

H.B. 7 and H.B. 410 - Mandates the inclusion of chiropractic coverage in all Blue Cross/Blue Shield policies.

H.B. 166 - Creates the Lay Midwifery Practice Act -- provides for lay midwives to perform home deliveries.

H.B. 1011 - Mandates the inclusion of clinical social worker coverage Blue Cross/Blue Shield policies.

H.B. 2406, H.B. 2771, S.B. 1007 - Increases licensing fees.

H.B. 2441 - Prolongs the statute of limitations for medical malpractice cases.

S.B. 1326 - Requires that health insurance policies reimburse fully licensed physicians and podiatrists at identical rates.

While I can't make a direct correlation between physician involvement and the defeat of any of these bills, I can assure you, were it not for the involvement of your fellow physicians from across the state, many of these bills would be law today. It's a frightening thought. Not just for our profession, but for our patients as well.

Physician political involvement through IMPAC doesn't guarantee a vote in support of medicine's position -- it does guarantee, however, that a legislator will be willing to listen to our perspective -- and frequently that willingness to listen is all that is required. The future could be frightening...



Herbert Sohn, M.D.  
Chairman

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

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# Student Business Session in Action

## Interim Meeting of AMA House of Delegates

Honolulu was the site of the most recent gathering of the AMA House of Delegates (HOD) in December, 1979. For the students of the SBS it was a significant gathering indeed. Below I shall summarize briefly the actions of the HOD relevant to student proposals. HOD actions can be grouped according to their impact on the structure of the SBS, the conduct of medical education, the stance of the AMA on public health issues and the personal issues secondary to medical education and practice.

Perhaps the most significant organizational step of the HOD regarding the SBS was restructuring the SBS Governing Council to include four members from demographic regions in the SBS and one member appointed by the American Medical Student Association.<sup>1</sup> It remains to be seen how this action will affect relations between the SBS and other medical student organizations. Also adopted was a report allowing students on AMA councils voting privileges at the discretion of the Council involved<sup>2</sup> and a recommendation to minimize financial impediments to student membership in the AMA, state and county medical societies.<sup>3</sup>

Proposals before the HOD spoke to medical education in a variety of ways. Medical research was proposed as a means for repayment in some government scholarship and loan programs.<sup>4</sup> Further study was given to the role of standardized examination for purposes other than licensure with associated issues of confidentiality of student records and varied state exam requirements.<sup>5</sup> Integration of qualified students from foreign medical schools received continued support, as did the "Fifth Pathway" program.<sup>6</sup> Greater flexibility was recommended for residency interview scheduling<sup>7</sup> and arrangement of medical education loan repayment.<sup>8</sup> Finally, increased availability of AMA Drug Evaluation for both students and residents was placed before the Board of Trustees for consideration.<sup>9</sup>

A number of public health issues received attention from the HOD. Among them were the following student initiatives. In response to an ISMS/SBS proposal, the HOD gave support to strict penalties in crimes involving fire arms.<sup>10</sup> Incorporation of environmental concerns into medical school programs also received support.<sup>11</sup>

Continued research into immunization technology with domestic and international applications was backed.<sup>12</sup> Increased support was given to rights of non-smokers on commercial aircraft. Consideration was given to further segregation of smokers and non-smokers, along with a decrease in cigarette advertising; these questions were referred for further study by the Board of Trustees.<sup>13</sup>

Finally, the HOD spoke to some of the social concerns within medical training and practice. The Council on Medical Education reported on its continuing studies of the status of minority students in medical education.<sup>14</sup> Support also came to resolutions allowing residency flexibility for pregnant housestaff<sup>15</sup> and maintenance of child care centers in or near medical centers and hospitals.<sup>16</sup> The Board of Trustees was asked to consider a resolution discouraging psychological testing of medical students in medical schools in the absence of informed consent.<sup>17</sup>

Above is only a brief summary of a fraction of the HOD work. It serves as fitting evidence of a real role for student participants in the AMA. We look to the new year with renewed enthusiasm as organized medicine moves to meet the unique challenges now faced by medical professionals. ◀

David J. Dries  
Secretary/Editor

### References\*

1. Resolution 94
2. Report A of Council on Constitution and Bylaws
3. Resolution 92
4. Resolution 79
5. Report G of Council on Medical Education, Resolutions 110 (I-78), 48 (A-79)
6. Report G of the Board of Trustees
7. Resolution 93
8. Report F of Council on Medical Education
9. Resolution 82
10. Resolution 88
11. Resolution 91
12. Resolution 37
13. Report J of Board of Trustees, Resolution 85, 86
14. Report I of Council on Medical Education
15. Resolution 89
16. Resolution 90
17. Resolution 36

\*Taken from: "Actions Taken by the AMA House of Delegates," Honolulu, Hawaii, December 2-5, 1979.

*This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Student Business Session.*

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**WANTED—INTERNIST** at Veterans Administration Medical Center, Marion, IL. Beginning salary up to \$50,112 per year depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any State. Contact Chief of Staff, VA Medical Center, Marion, IL 62959, Telephone (618) 997-5311. An Equal Opportunity Employer.

**PSYCHIATRIC PRACTICE.** Lucrative hospital and office practice in pleasant west suburban Chicago area. Growing area with excellent potential. Reason for selling—entering residency program. Available July 1 or before. Reply in strict confidence to: Box #963, c/o Ill. Medical Journal, 55 E. Monroe, Suite 3510, Chicago, 60603.

**WANTED—BOARD ELIGIBLE OR CERTIFIED** family practitioner to associate with two board certified physicians in affluent Northwest suburb. Contact Box #961 c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.



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**PHYSICIAN FOR FAMILY PRACTICE WANTED**—Fairview Heights, Illinois. Send Resume. 10,700 Lincoln Trail Drive, Fairview Hgts., Ill. 63108.

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## “I Quit” Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of “I Quit Smoking” clinics around the state. The clinics are held for five days in 1½ hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, but the remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

March 4	Daley Center	Chicago
March 9	Hinsdale Sanitarium & Hospital	Hinsdale
March 9	Memorial Hospital of Elmhurst & A.C.S.	Elmhurst

March 10	Lake Forest Hospital & A.C.S.	Lake Forest
April 8	Daley Center	Chicago
April 13	Hinsdale Sanitarium & Hospital	Hinsdale
April 14	Christ Hospital	Oak Lawn
April 14	Condell Memorial Hospital & A.C.S.	Libertyville
April 28	Lutheran General Hospital	Park Ridge
May 6	Daley Center	Chicago
May 11	Hinsdale Sanitarium & Hospital	Hinsdale
June 3	Daley Center	Chicago
June 8	Hinsdale Sanitarium & Hospital	Hinsdale
June 23	Christ Hospital & A.C.S.	Oak Lawn
July 28	Lutheran General Hospital	Park Ridge
September 15	Christ Hospital	Oak Lawn
October 6	Lake Forest Hospital & A.C.S.	Lake Forest
October 27	Lutheran General Hospital	Park Ridge
November 17	Christ Hospital	Oak Lawn

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# REPORT

## FOR *Illinois Physicians*

### Medical Necessity Project List Updated

A new list of surgical and diagnostic procedures which require satisfactory justification from physicians before Blue Cross and Blue Shield Plans will make payments for them has been prepared.

The new list, below, replaces lists previously published. It should be used as the listing of procedures currently included in the Medical Necessity Project, discussed in previous articles.

It is *not* the intent of the Chicago-based Blue Cross and Blue Shield Plan to deny payment for these procedures, leaving patients with the obligation to pay for them. Rather, the Plan's intent is to encourage physicians to review their practices and alter them appropriately.

There may, of course, be situations when some of

the listed procedures will be medically justified. We ask only that claims include information indicating the special circumstances dictating the exceptional use of the procedure.

Please Note: The numbers in parentheses after the procedure identify the following society endorsement: (1) American College of Surgeons; (2) American College of Radiology; (3) American College of Physicians; (4) Illinois Psychiatric Society; (5) Illinois Society of Pathology; (6) American Academy of Dermatology; (7) College of American Pathologists; (8) American Academy of Family Physicians; (9) American Academy of Neurology; (10) American Academy of Pediatrics, and (11) American Psychiatric Association.

### Procedures Payable Only Upon Satisfactory Justification

PROCEDURE DESCRIPTION	REASON(S) FOR DELETION
Amylase, blood isozymes, electrophoretic (3 & 7)	Not clinically useful
Angiocardiography, multi-plane, supervision and interpretation in conjunction with cineradiography, and (2)	
Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography (2)	
Angiocardiography, utilizing CO <sub>2</sub> method, supervision and interpretation only (2 & 3)	
Angiography—coronary, unilateral selective injection supervision and interpretation only, single view unless emergency (2 & 3)	
Angiography—extremity, unilateral, supervision and interpretation only, single view unless emergency (2)	
Autogenous vaccine (3 & 6)	No proven value
Ballistocardiogram (3)	
Basal metabolic rate (BMR) (3)	
Bendien's test (3 & 7)	Based on false premise; not informative or diagnostic
Bolen test (3 & 7)	Based on false premise; not informative or diagnostic
Bronchoscopy—with injection of contrast medium for bronchography (2)	
Bronchoscopy—with injection of radioactive substance (2)	
BSP (5)	
Calcium clotting time (3 & 7)	Obsolete test
Calcium, feces, 24-hour quantitative (3 & 7)	Obsolete test
Calcium saturation clotting time (3 & 7)	Obsolete test
Capillary fragility test (Rumpel-Leede) (independent procedure) (3 & 7)	Superfluous
Cephalin Flocculation, thymol turbidity (3 & 7)	Obsolete test
Cerebellar stimulator pacemakers for cerebral palsy (9)	Experimental. Value not proven
Chelation therapy (3 & 8)	Chelation therapy with EDTA has been used in the treatment and prevention of atherosclerosis. Because of the risk of severe renal toxicity and lack of objective evidence suggesting therapeutic benefit from EDTA therapy for atherosclerotic disease, such therapy should be regarded as investigational and conducted under carefully controlled conditions in an academic institution by experienced investigators.
Chromium, blood (3 & 7)	No Clinical indication
Chymotrypsin, duodenal contents (3 & 7)	Unreliable
Circulation time, one test (3 & 6)	Obsolete

(This report is a service to the physicians of Illinois)

PROCEDURE DESCRIPTION	REASON(S) FOR DELETION
Circumcision, female (1)	
Colloidal gold (3 & 7)	Obsolete test
Congo red, blood (3 & 7)	Obsolete test
Fabric wrapping of abdominal aneurysm (1)	
Gastric analysis pepsin (3 & 7)	Not informative
Gastric analysis, tubeless (3 & 7)	Unreliable
Guanase, blood (3 & 7)	Obsolete test
Hair analysis test (3, 6 & 7)	Obsolete, inaccurate; replace by heavy metal mobilization test
Hormones, adrenocorticotropin quantitative animal tests (3 & 7)	Obsolete test
Hormones, adrenocorticotropin quantitative bioassay (3 & 7)	Obsolete test
Hyperbaric oxygen therapy for atherosclerosis (3)	No scientific evidence supporting effectiveness
Hyperbaric oxygen therapy for cerebral vascular impairment (3 & 9)	No scientific evidence supporting effectiveness
Hyperbaric oxygen therapy for heart attack (3)	No scientific evidence supporting effectiveness
Hyperbaric oxygen therapy for senility (3 & 9)	No scientific evidence supporting effectiveness
Hyperbaric oxygen therapy for sickle cell anemia crises (3 & 10)	No scientific evidence supporting effectiveness
Hyperbaric oxygen therapy for stroke (3 & 9)	No scientific evidence supporting effectiveness
Hypogastric or presacral neurectomy (independent procedure) (1)	
Hysterotomy, non-obstetrical, vaginal (1)	
Icterus index (3)	
Intragastric hypothermia using gastric freezing (3)	No scientific basis
Kidney decapsulation, bilateral (1)	
Kidney decapsulation, unilateral (1)	
Ligation of internal mammary arteries, bilateral (1)	
Ligation of internal mammary arteries, unilateral (1)	
Ligation of thyroid arteries (independent procedure) (1)	
Mucoprotein, blood (seromucoid) (3 & 7)	Obsolete test
Nephropexy: fixation or suspension of kidney (independent procedure), unilateral (1)	
Omentopexy for establishing collateral circulation in portal obstruction (1)	
Orthomolecular medication and megavitamin therapy for use in relation to learning disabilities, mental illness (particularly, schizophrenia and certain aberrant emotional conditions), hypoglycemia and other non-casually related types of conditions (3 & 11)	No scientific validity exists and excessive amounts of vitamins A, C, D could be toxic
Perirenal insufflation (1)	
Phonocardiogram with interpretation and report and with direct carotid artery tracing or similar study (3)	
Prolotherapy (3)	Not effective
Protein bound iodine (PBI) (3)	
Radical hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area (1)	
Rehfuß test (3 & 7)	Not informative
Skin test, actinomycosis (3 & 6)	Deleted by Center for Disease Control (CDC)
Skin test, brucellosis (3 & 6)	Deleted by CDC, 1976
Skin test, cat scratch fever (3 & 6)	Deleted by Center for Disease Control (CDC), 1976. Test material not available commercially.
Skin test, leptospirosis (3 & 6)	Deleted by CDC, 1976
Skin test, lymphopathia venereum (Frei test) (3 & 6)	Non specific; positive with other Chlamydial diseases
Skin test, psittacosis (3 & 6)	Deleted by CDC, 1976
Skin test, trichinosis (3 & 6)	Deleted by CDC, 1976
Spinal Fluid Pandy (5)	
Starch, feces, screening (3 & 7)	Not informative; impossible to interpret
Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both (1)	
Thymol turbidity, blood (3 & 7)	Obsolete test
Transorbital Frontal Lobotomy (4)	
Uterine suspension (1)	
Uterine suspension, with presacral sympathectomy (1)	
Zinc sulphate turbidity, blood (3 & 7)	Obsolete test

## Procedures Payable When Performed For The Specific Condition Indicated

PROCEDURE DESCRIPTION	CONDITIONS
Excision of carotid body tumor without excision of carotid artery (1)	asthma
Extra-intra cranial arterial bypass (1)	complete stroke
	Carotid artery obstructive disease not amenable to endarterectomy, symptomatic
	Middle cerebral artery obstructive disease, symptomatic
	Vascular or neoplastic lesions risking occlusion of major cerebral artery during operative correction
Fascia lata by incision and area exposure, with removal of sheet (1)	lower back pain
Fascia lata by stripper (1)	lower back pain
Ligation of femoral vein, bilateral (1)	post-phlebotic syndrome
Ligation of femoral vein, unilateral (1)	post-phlebotic syndrome
Sympathectomy, lumbar, bilateral (1)	hypertension
Sympathectomy, lumbar, unilateral (1)	hypertension
Sympathectomy, thoracolumbar, bilateral (1)	hypertension
Sympathectomy, thoracolumbar, unilateral (1)	hypertension
Splanchnicectomy, bilateral (1)	hypertension
Splanchnicectomy, unilateral (1)	hypertension





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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

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# Clinics for Crippled Children Listed for April

Thirty-nine clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 10 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- April 1 Park Ridge Cardiac (a.m.)—Lutheran General Hospital
- April 1 Park Ridge General (p.m.)—Lutheran General Hospital
- April 1 Maryville—Oliver C. Anderson Hospital
- April 1 Wheaton General—Marianjoy Rehab. Hosp.
- April 1 Quincy—Blessing Hospital
- April 1 Danville—Lake View Hospital
- April 2 Aurora MM—Mercy Center for Health Care Services
- April 2 Hinsdale—Hinsdale Sanitarium
- April 2 Metropolis—Massac Memorial Hospital
- April 3 Sterling—Community General Hospital
- April 3 Litchfield—St. Francis Hospital
- April 3 Lake County Cardiac—Victory Memorial Hospital
- April 8 East St. Louis—Community Hospital
- April 9 Rockford—St. Anthony's Hospital
- April 9 Champaign-Urbana—McKinley Hospital
- April 9 Cairo—Southern Seven Health Dept.
- April 9 Elgin General—Sherman Hospital
- April 9 Joliet—St. Joseph's Hospital
- April 10 Springfield—St. John's Hospital
- April 10 Kankakee General—St. Mary's Hospital
- April 10 Aurora Cardiac—Mercy Center for Health Care Services
- April 11 Division Cardiac—U. of I. at the Medical Center
- April 14 Peoria Cardiac—St. Francis Hospital
- April 14 Chicago Heights Cardiac—St. James Hosp.
- April 15 Rock Island Area General—Moline Public Hospital
- April 15 Maywood—Loyola Medical Center
- April 15 Decatur-Decatur Memorial Hospital
- April 16 Chicago Heights General—St. James Hosp.
- April 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
- April 17 Rockford—Rockford Memorial Hospital
- April 17 Bloomington—Mennonite Hospital
- April 18 Kankakee Cardiac—St. Mary's Hospital
- April 25 Evanston—St. Francis Hospital
- April 28 Peoria Cardiac—St. Francis Hospital
- April 28 Chicago Heights Cardiac—St. James Hosp.
- April 29 Peoria General—St. Francis Hospital
- April 29 Belleville—St. Elizabeth's Hospital
- April 30 Springfield Ped-Neuro—St. John's Hospital
- April 30 Aurora General—Mercy Center for Health Care Services

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

Please consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

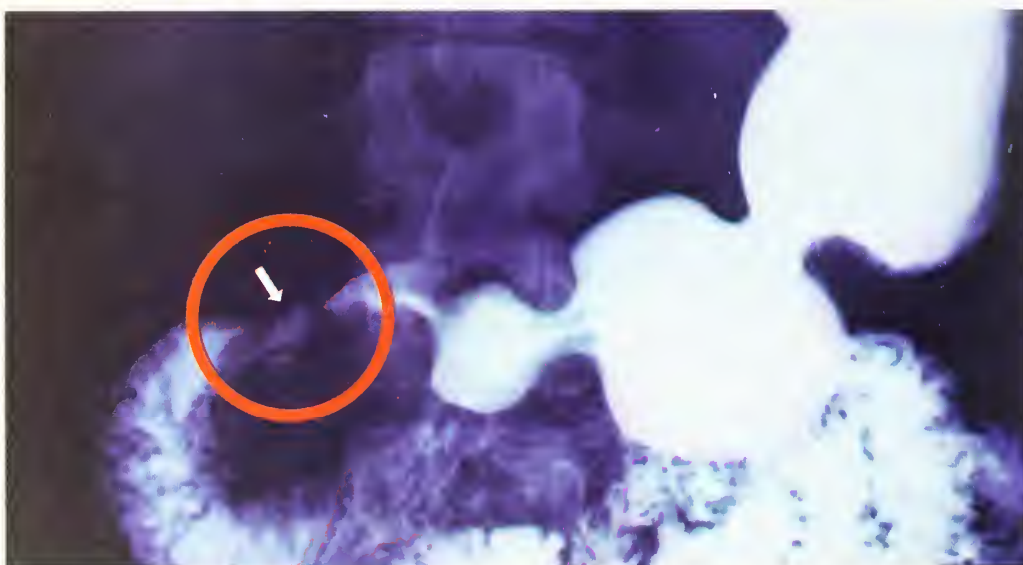


Roche Products Inc.  
Manati, Puerto Rico 00701

# The stress-secretion relationship in duodenal ulcer\*



The pituitary gland plays a key role in the neurohormonal response to emotional stress, leading to an increase in gastric secretion.<sup>2</sup>



The duodenal ulcer reflects the erosion of a vulnerable mucosa by acid-pepsin secretion.<sup>2</sup>

The best available evidence<sup>1,2</sup> suggests that chronic anxiety stimulates acid-pepsin secretion. Also, the development of an ulcer crater in predisposed individuals, or the aggravation of ulcer symptoms, is often associated with a stressful event or situation.<sup>1</sup> Thus, anxiety seems to play an important role in the course and prognosis of the disease.<sup>1</sup>

To obtain more comprehensive relief, many duodenal ulcer patients need more than specific, acid-inhibiting medication. They also need reduc-

tion of accompanying anxiety and emotional tension.

**References:** 1. Isenberg J, Richardson CT, Fordtran JS. Pathogenesis of peptic ulcer, chap. 46, in *Gastrointestinal Disease*, ed. 2, edited by Sleisenger

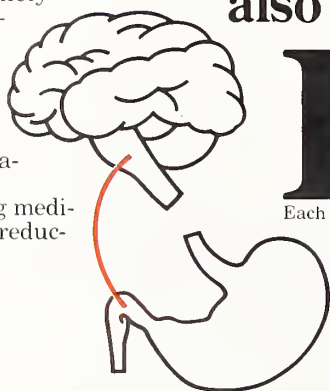
MH, Fordtran JS. Philadelphia, WB Saunders Company, 1978, vol. 1, pp. 800-801. 2. Sun DCH. Etiology and pathology of peptic ulcer, chap. 27, in *Gastroenterology*, ed. 3, edited by Bockus HL, et al; Philadelphia, WB Saunders Company, 1974, pp. 579-595.

**More than an antisecretory agent...  
also acts on accompanying anxiety**

Adjunctive  
**Librax**<sup>®</sup>

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**antianxiety/antisecretory/antispasmodic**



ROCHE

\*Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on preceding page.



# Abstracts of Action

February 2-3, 1980

Washington, D. C.

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## FINANCIAL/ADMINISTRATIVE MATTERS

The Board approved a 1980 ISMS budget projecting a \$112,338 deficit. The budget reflects income of \$2,343,710 and expenses of \$2,456,048. The deficit resulted when the Board voted to strictly adhere to the five-year dues maintenance plan—adopted by the House in 1978—which calls for contributions of approximately \$309,000 to Reserve Accounts. Outside sources of funding will be sought to aid in achieving a balanced budget. In other actions concerning the 1980 budget, the Board:

- Approved a Benevolence Fund budget of \$195,750 income and \$56,000 expenses.
- Requested that Illinois State Medical Insurance Services increase its financial support of the ISMS Task Force on Professional Liability Risk Management Program . . . and voted to bill Illinois State Medical Inter-Insurance Exchange for the cost of ISMS legislative services on its behalf in Springfield.
- Authorized a \$162,785 contribution to ICCME for 1980. In related action, the Board declined a request by the ICCME Board of Directors to sponsor an ICCME funding resolution at the annual meeting . . . but instructed the ISMS Board chairman to inform the House of Delegates in his annual report that ICCME funding is the fiduciary responsibility of the Board, which fully intends to continue the Society's support of the organization unless otherwise instructed by the House.

In other actions involving finances, the Board:

- Agreed to recommend that the House of Delegates adopt a resolution to increase—from \$1 to \$3—the special assessment that supports activities of the Student Business Session and Resident Physicians Section. The increase would take effect next year.
- Authorized a \$150 contribution to the Illinois Interagency Council on Smoking. The contribution, in effect, represents the Society's 1979-80 membership dues in the agency.

Acting on administrative matters, the Board:

- Adopted a resolution to indemnify members of all ISMS councils, committees and task forces as well as the Illinois Council on Continuing Medical Education.
- Granted a charter to the newly-created Marshall-Putnam County Medical Society, entitling the society to representation in the ISMS House of Delegates at the upcoming annual meeting.
- Recognized the recently-formed Illinois State Urological Society—composed of the Chicago Urological Society and Illinois Urological Society—and authorized the groups to name a delegate and alternate to the ISMS House of Delegates. The new arrangement does not alter House composition, because the seats in the House and membership on ISMS Council on Affiliate Societies previously were held by the Chicago Urological Society, now a component of the state group.

## GROUP INSURANCE PROGRAMS

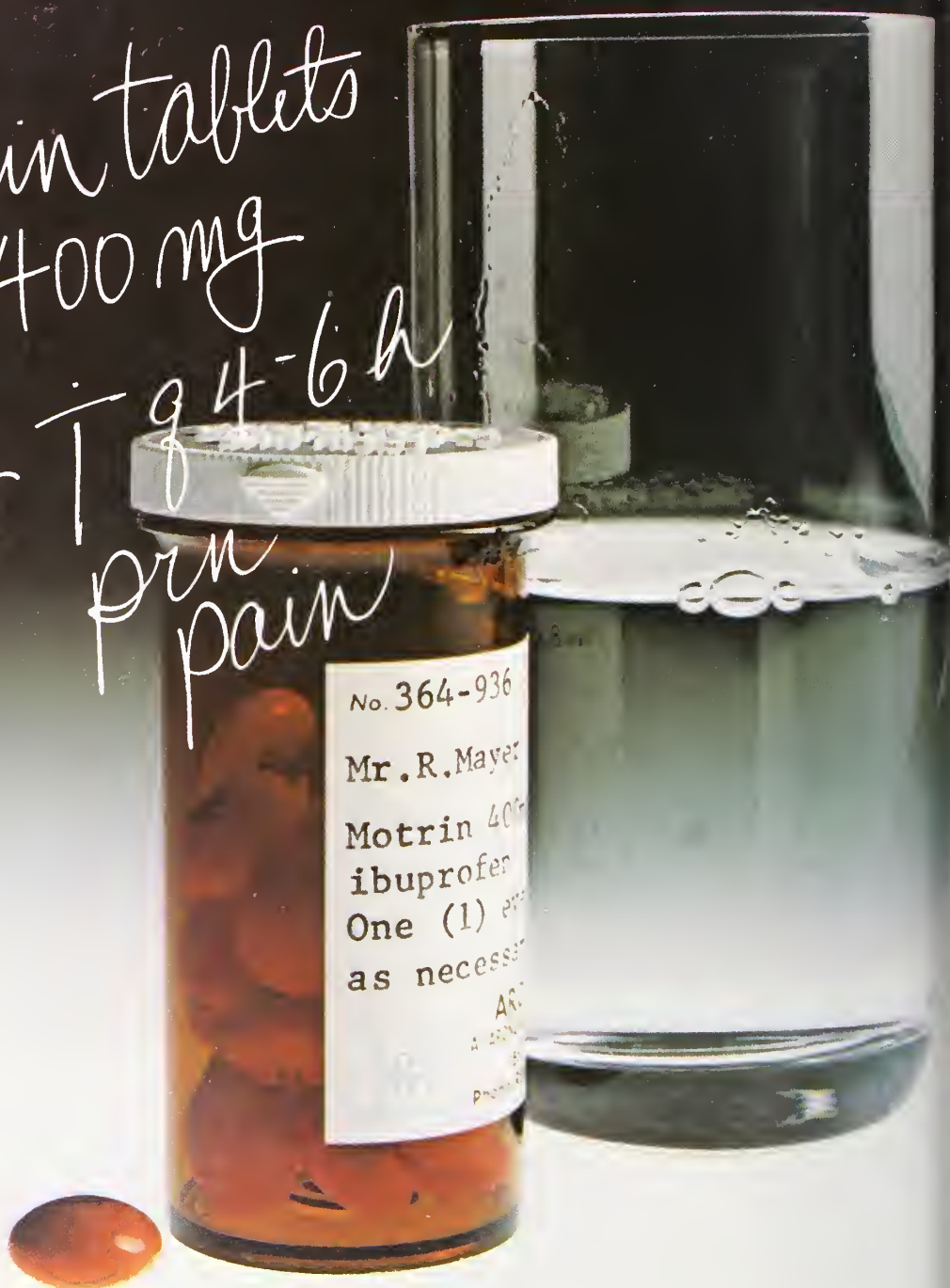
The Board authorized Carroon & Black of Illinois, Inc.—a Chicago brokerage firm—to assume administration of six ISMS-sponsored group insurance programs. The move will eliminate administrative fragmentation and permit overall upgrading of the plans. The programs—currently handled by four different insurance administrators—are: Disability, Business Overhead, Hospital Indemnity, Life, Major Medical, and Excess Major Medical. The C&B takeover will be gradual to avoid disruption of billing patterns and other processes. In addition, C&B will help ISMS prepare to eventually assume administration of all Society-sponsored insurance programs.

*(Continued on page 192)*

A well-tolerated, nonnarcotic prescription for pain

Motrin tablets  
400 mg

Sig T q 4-6 h  
prn  
pain





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# Pulse of the ISMS Auxiliary



## Smoke Gets in Your Eyes

BY MRS. R. SAMUEL HOOVER, ISMSA

Smoke gets in your eyes, and your mouth, and your throat, and your lungs. Also in your hair, in your clothes, in your car, and in your family room. It affects others as well as yourself. It is a questionable pleasure; one we could easily or not so easily do without. Would you like to quit? With due apologies to Mark Twain, who said, "Anyone can quit smoking: I've done it myself dozens of times," *you really can.*

At the AMA House of Delegates session in July, 1979, an expanded campaign against cigarette smoking and other tobacco products was adopted. The program was developed by the Council on Scientific Affairs, and recommended specific actions for the AMA, individual physicians, government and private agencies—all geared to combat the growing health hazard of excess smoking. The report called for the AMA to develop anti-smoking and smoking cessation educational materials for physicians, anti-smoking package programs for medical societies, and a "Health Self-Awareness" smoking cessation kit for consumers.

The AMA House of Delegates also passed several other resolutions related to smoking. Two resolutions deal with tobacco advertising: one to request television networks to halt tobacco product commercials containing athlete endorsements, and another, to commend publications that have refused to accept tobacco advertisements. Stronger warning language on cigarette packages was also recommended, as well as a readjustment increasing cigarette taxes and production of less hazardous and less toxic tobacco. The FTC was

urged to restrict further advertising and to prohibit promotions aimed at teenagers. Insurance companies were urged to consider reduction of non-smokers' premiums. Most importantly, the report concluded that state, national, and local medical and specialty societies should encourage their members to make more vigorous anti-smoking efforts. Anti-smoking materials are available from the AMA office for interested societies and auxiliaries.

No matter how you look at it, smoking is hazardous to your health. The documented information has been around since 1964, and each further public health report just adds to the original conclusions of the famous (or infamous) Surgeon General's Report. The latest surgeon general's report to Congress indicates to American women that "You've come a long way, Baby," toward meeting American men's rate of lung cancer deaths related to smoking. Lung cancer among women is increasing dramatically and may, within three years, overtake breast cancer to become the leading cancer killer of women. "Cigarette smoking, an early sign of woman's emancipation, is now a major threat to her personal health and her ability to bear healthy children," said Surgeon General Julius B. Richmond, M.D. Dr. Richmond's report emphasizes that pregnant women who smoke run an increased risk before, during and after childbirth. Statistics showed that the death rate for women by lung cancer remained fairly steady, less than five per 100,000, until the early 1960s, when it began to

*(Continued on page 158)*

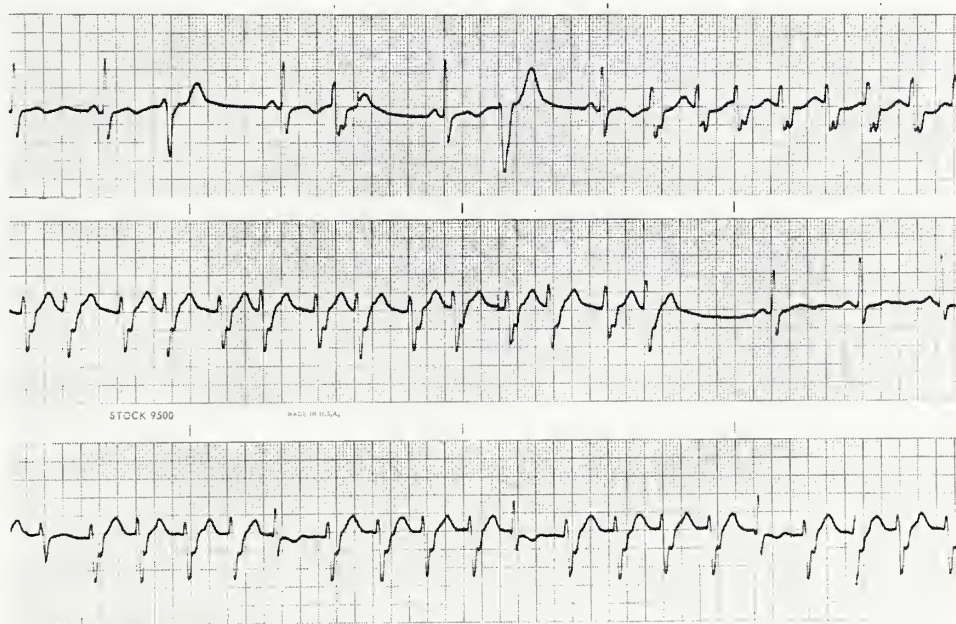


# EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., David J. Hole, M.D., Patrick J. Sconlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnor, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

The patient is a forty-nine year old man who was in good health until July of 1977. At that time, he had an acute inferior wall myocardial infarction. He had an uncomplicated course and subsequently returned to work. For the next two years he remained asymptomatic. In mid-1979 he first complained of palpitations. A series of twenty-four hour Holter monitor recordings demonstrated the palpitations. The longest recorded episode of tachycardia lasted nearly twenty min-

utes. No symptoms of chest pain or lightheadedness ever occurred during the bouts of palpitations. Empirical management of the tachycardia with various medications was not successful. A cardiac catheterization was performed which included hemodynamics, coronary angiography, HIS bundle recordings, and atrial and ventricular pacing. A sample of one of the Holter recordings is shown.



## Questions:

1. The electrocardiographic diagnosis that best fits the tachycardia shown on the rhythm strip is:
  - A. Paroxysmal ventricular tachycardia.
  - B. Paroxysmal atrial fibrillation with aberrant intraventricular conduction.
  - C. Paroxysmal atrial flutter with aberrant intraventricular conduction.
  - D. Paroxysmal atrial tachycardia with aberrant intraventricular conduction.
  - E. None of the above.

2. Some electrocardiographic clues to the diagnosis of ventricular tachycardia are:
  - A. Atrioventricular dissociation.
  - B. Distinct and isolated premature ventricular beats whose QRS contour resembles the QRS of the ventricular tachycardia.
  - C. Atrial capture beats.
  - D. Fusion beats.
  - E. All of the above.

(Continued on page 189)

# Are you prescribing a regimen of **PLAIN ASPIRIN EVERY DAY?** **BUFFERIN® WAS SIGNIFICANTLY BETTER TOLERATED IN LONG-TERM ADMINISTRATION**



**In a particular series of 14-day gastric tolerance studies among 182 normal subjects, 49% suffered G.I. upset from plain aspirin. Most of these subjects took BUFFERIN without discomfort.**

Subjects in these controlled trials, which utilized a crossover design, were given Bufferin and Bayer® Aspirin for two weeks each in a balanced order of administration. The cumulative gastric tolerance superiority of Bufferin over plain aspirin was significant ( $P < .01$ ) from day one and persisting through each day of the study. This superiority for an extended period could be of particular

importance to patients on repeat-dosage schedules.

For full aspirin benefits, together with excellent gastric tolerance, Bufferin should be your brand of choice. If you are prescribing a regimented daily dose of aspirin, prescribe Bufferin—the repeat-dosage aspirin—instead.

## **BUFFERIN: The Repeat-Dosage Aspirin.**

For complimentary samples of Bufferin and Arthritis Strength Bufferin, please write: Bufferin, P.O. Box 65, Elizabeth, New Jersey 07207. Composition: Each Bufferin tablet contains aspirin 324 mg. and the antacid Di-Alminate® (Bristol-Myers' brand of Aluminum Glycinate 48.6 mg. and Magnesium Carbonate 97.2 mg.).

© 1978, Bristol-Myers Co.



# Illinois Housestaff News

BY LINDA HUGHEY HOLT, M.D., SECRETARY/EDITOR

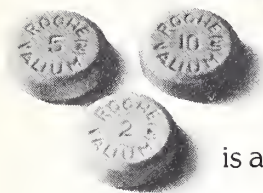
The ISMS-RPS recently received a letter from a disgruntled resident. The resident, in his first year of postgraduate training, was an American born foreign medical graduate. He felt he was encountering generalized discrimination due to being foreign-trained.

His letter is of interest in that it raises several very basic questions about the very nature of discrimination. (1) Are FMG's really receiving different treatment than USMG's? Most of the problems raised in the letter received by the RPS were problems encountered by all interns. He raised the issue of nurses questioning orders—but what intern has not had orders questioned (and at times been grateful that a wrong order was called into question!) With residents being challenged daily by nurses and by Attendings, it is difficult to know whether an individual complaint represents a malicious challenge of a resident's authority or the type of healthy day-to-day questioning which improves patient care. (2) Is different treatment justified in an individual situation? Even if a given FMG is treated differently, it does not constitute discrimination unless there is no other reason. We all know residents, both foreign and American-trained, who need constant questioning and surveillance to keep them in line. Discrimination occurs only when someone is unjustifiably questioned. (3) Are communication problems causing an FMG to underachieve? Failure to communicate well with pa-

tients and staff can cause FMG's to appear less knowledgeable than they are. Anyone who has tried to limp through a discussion with his high-school French can appreciate that it is difficult to seem intelligent if not at ease with the language. Obviously the language barrier is *not* a factor in difficulties encountered by USFMG's, but for foreign-born FMG's poor communication can cause serious problems. (4) What responsibilities do hospitals have to their residents? Many residents complain of programs which they feel use them as cheap labor while investing very little time or effort into resident education. FMG's often must accept positions in the less desirable programs. Furthermore, program directors and Attendings may take the attitude that FMG's should be grateful to be *in* a training program in the United States and hence may be unresponsive to their complaints. But residency training programs have the same responsibility (as outlined in the *Essentials of Graduate Medical Education*) to FMG's as to any other resident.

The ISMS-RPS is concerned about the question of problems encountered by FMG's and would like to hear of those problems. No doubt many of the difficulties encountered by FMG's are simple individual problems which can be encountered by any resident. But if either residents or program directors have encountered difficulties which they feel are specific to foreign training, please write to this column and we shall explore the problem in future issues. ◀

# A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

## Valium®<sup>IV</sup> diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets  
a prudent choice in psychic  
tension and anxiety

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110





# IMJ

*Illinois Medical Journal*

Vol. 157, No. 3, March, 1980

## An Evaluation of the Dial Access Cancer Education System in Illinois

JAN W. STEINER, M.D., DENISE OLESKE, R.N., M.P.H., KENNETH LUURS, B.A.,  
ALAN LIPSITZ, M.S., AND LORRAINE C. HANNAH

The Cancer Information Service (CIS) of the Illinois Cancer Council (ICC), the designated Comprehensive Cancer Center for the Illinois region, was funded by the National Cancer In-

stitute to serve as a resource providing the most current information concerning cancer risk, prevention, treatment and rehabilitation to Illinois health professionals and lay public. The ICC-CIS has provided direct access to vital cancer information via a statewide toll-free WATS line (800-972-0586) since July 1, 1975.

JAN W. STEINER, M.D., is director of the Comprehensive Cancer Center for the State of Illinois—Illinois Cancer Council. A pathology fellow of the Royal College of Physicians and Surgeons of Canada, Dr. Steiner also serves as professor of large and planning consultant, Faculty of Arts and Science, University of Toronto, where he is also an associate dean in planning and development for the Faculty of Medicine.



DENISE OLESKE, R.N., is coordinator of the oncology nursing program, Illinois Cancer Council, Chicago. A lecturer for the Rush University graduate program in oncology nursing, Ms. Oleske holds a masters' degree in public health. She is a member of the American Association for Cancer Education subcommittee on community professional education.

KENNETH J. LUURS is a communication specialist for the Illinois Cancer Council. He is a member of both the National Association of Social Workers and the American Psychological Association.

ALAN J. LIPSITZ is a program associate in the Illinois Cancer Council division of cancer control. He holds a masters degree in public health and notes a particular interest in psychosocial aspects of terminal care.

LORRAINE C. HANNAH is director of the administrative division and also the division of cancer control, Illinois Cancer Council Comprehensive Cancer Center. Ms. Hannah has held a number of professional health positions in health services planning and management.

Staffed by professional information specialists, the CIS relies upon a broad information base. This includes the expertise of nearly 300 Illinois physicians, computer retrieval from the National Library of Medicine, in-house literature and resource files, information available to the Division of Research Resources of the Illinois Cancer Council, as well as the National Cancer Institute and other cancer centers. Inquiries for information can be answered utilizing whichever resource is most appropriate. For example, a physician requesting treatment information for a given patient may best be assisted through the arrangement of a free physician-to-physician consultation.<sup>1</sup> Requests for information on a given therapeutic protocol might be answered through on-line retrieval, contact with another center, or from office resources. In all instances every attempt is made to respond to a request within one working day.

In September of 1976, the Dial Access System was added to the list of services offered by the ICC-CIS in an effort to broaden the educational options available to those Illinois health professionals involved in the management of cancer patients. Introduction of the Dial Access System was made possible through the joint efforts of the ICC, the Illinois State Medical Society, and the M.D. Anderson Hospital and Tumor Institute in Houston, Texas.

**Table 1**  
**Distribution of Professionals Utilizing the**  
**Dial Access System, September 1, 1976 to**  
**June 30, 1977**  
**(N=414)**

Professional Group	Number of Callers	Percentage of Total
Physicians	340	82.13
Osteopaths	2	0.48
Nurses (incl. students)	48	11.59
Pharmacists	6	1.45
Dentists	3	0.73
Health Educators/counselors	6	1.45
Other (health professionals)	7	1.69
Other (non-health professionals)	2	0.48
Total	414	100.00

**Table 2**  
**Tapes listened to through**  
**the Dial Access System by**  
**Illinois Health Professionals**  
**September 1, 1976-June 30, 1977**

Month	No. of Tapes	Standings of Illinois in Relation to Other States in System
<b>1976</b>		
September 1	*	—
October	46	14
November	25	16
December	72	4
<b>1977</b>		
January	221	2
February	327	1
March	182	3
April	77	5
May	78	3
June	109	2
<b>Total</b>	<b>1137**</b>	

\* System initiated, Phase 1 Promotions to Physicians Begins

\*\* 911 of these were heard by physicians

The purpose of this article is to evaluate the use of this method of cancer education among physicians. Although this evaluation takes into account only the first 10 months of operation (which coincides with the end of the ICC's fiscal year), it is possible to make some inferences about the receptivity of physicians to this new educational resource on cancer, as well as on their response to promotion of this service.

### The Dial Access System

Although the Dial Access System is physically located in Houston, Texas, toll-free telephone calls interchangeable among eight WATS lines

enable health professionals to listen to taped narrations of cancer topics without incurring a charge. A secretary receiving the incoming calls asks for identification including name, address, and profession and for the number(s) of tape recordings desired. There are currently over 350 tapes listed in the Dial Access catalog.

Each tape in the Dial Access library has a playing time of between six and eight minutes and is followed by three references. In addition to routine reviews and updates of existing tapes, new tapes are constantly added to expand the system. Manuscripts are provided by members of the M.D. Anderson staff, as well as other noted cancer authorities throughout the nation.\*\*\*

The hours of the service are from 9 a.m. - 9 p.m. (EST) Monday through Friday and 10 a.m. - 2 p.m. (EST) Saturday. At present all 50 states are utilizing the service.

### Evaluation Methodology

Although the system is available to dentists, nurses, medical students, and other health professionals, the physician community was the primary target in the first phase of promotion of the Dial Access System. With the assistance of the Illinois State Medical Society, all 14,140 members were sent complimentary catalogs of the Dial Access listings. This mass mailing took place between October, 1976 and January, 1977. During this same time period, catalogs were distributed to physicians at numerous symposia, workshops, conferences, and conventions. In addition, descriptions of the service were presented in the *Illinois Medical Journal* (December, 1976) and the ICC newsletter (circ. 1000).

In order to evaluate the trends in utilization of the Dial Access System among physicians in Illinois, the ICC-CIS requested raw data from the System's Houston headquarters for the first ten months of operation (September 1, 1976-June 30, 1977). The data were tabulated and cross-validated by the ICC staff. Information on the number and location of practicing physicians in Illinois was obtained from the Illinois State Medical Society.

### Results

During the ten month evaluation period, 1137 tapes were heard by all categories of Illinois health professionals (Table 2). Eighty-two percent of these tapes were heard by physicians (Table 1). During the first month of activity, September 1976, utilization of the Dial Access System in Illinois, relative to the rest of the

\*\*\*Manuscripts from Illinois physicians are welcome. An honorarium is awarded for manuscripts which have been reviewed and approved for use by the Dial Access System. For further information contact the ICC-CIS office.



**Table 3**  
**Physician Utilization Figures and Proportions**  
**for the 50 Counties using the Dial Access System**  
**from September 1, 1976-June 30, 1977.**

County	# of Practicing Physicians*	# of Physician Callers	Proportion of Physician Callers to those in Practice	# of Tapes Heard	Average # of Tapes Heard per Physician Call	# of Physician Calls	Average # of Calls per Physician
Adams	104	5	.04808	9	1.80	8	1.60
Bureau	36	1	.02778	17	17.00	5	5.00
Champaign	215	5	.02326	5	1.00	5	1.00
Clay	7	1	.14286	1	1.00	1	1.00
Clinton	11	2	.18182	9	4.50	7	3.50
Coles	36	1	.02778	13	13.00	5	5.00
Cook	8558	164	.01916	443	2.70	262	1.60
DeKalb	60	2	.03334	2	1.00	2	1.00
DeWitt	11	1	.09091	2	2.00	1	1.00
DuPage	613	18	.02936	45	2.50	30	1.67
Ford	13	1	.07692	1	1.00	1	1.00
Franklin	25	2	.08000	6	3.00	4	2.00
Henry	33	1	.03030	1	1.00	1	1.00
Iroquois	21	1	.04762	2	2.00	2	2.00
Jackson	71	1	.01408	1	1.00	1	1.00
Jefferson	26	1	.03846	6	6.00	3	3.00
Jersey	11	1	.09091	1	1.00	1	1.00
Jo Daviess	8	1	.12500	3	3.00	1	1.00
Kane	303	10	.03303	21	2.33	19	2.11
Kankakee	105	3	.02857	7	2.33	4	1.33
Lake	378	10	.02646	23	2.30	19	1.90
LaSalle	108	5	.04630	14	2.80	12	2.40
Lawrence	10	1	.10000	1	1.00	1	1.00
Lee	30	1	.03333	1	1.00	1	1.00
Logan	25	2	.08000	3	1.50	3	1.50
Macon	155	2	.01290	2	1.00	2	1.00
Madison	191	7	.03665	15	2.14	11	1.57
Marshall	9	1	.11111	5	5.00	5	5.00
Mason	6	1	.16667	15	15.00	8	8.00
Massac	3	2	.66667	16	8.00	8	4.00
Mercer	6	1	.16667	1	1.00	1	1.00
McHenry	77	4	.05195	4	1.00	4	1.00
McLean	121	1	.00826	1	1.00	1	1.00
Morgan	44	2	.04545	2	1.00	2	1.00
Ogle	15	3	.20000	3	1.00	3	1.00
Peoria	346	7	.02023	22	3.14	11	1.57
Richland	21	4	.19048	15	3.75	9	2.25
Rock Island	196	9	.04592	24	2.67	16	1.78
Saline	30	2	.06667	4	2.00	4	2.00
Sangamon	333	8	.02402	13	1.62	11	1.37
St. Clair	258	10	.03876	18	1.80	14	1.40
Stephenson	52	2	.03846	5	2.50	3	1.50
Tazewell	60	1	.01667	1	1.00	1	1.00
Union	7	1	.14286	1	1.00	1	1.00
Vermilion	101	2	.01980	2	1.00	2	1.00
Warren	14	1	.07143	2	2.00	2	2.00
Will	246	7	.02845	16	2.29	13	1.86
Williamson	36	2	.05556	11	5.50	6	3.00
Winnebago	393	19	.04835	58	3.05	47	2.47
White	8	2	.25000	4	2.00	2	1.00
<b>Totals</b>	<b>13546</b>	<b>342</b>		<b>897</b>		<b>586</b>	

\* Source: Illinois State Medical Society, Physician Members, 1976.

nation, was not assessed. Subsequent monitoring indicated that, following two months of relatively low utilization, Illinois emerged ranking among the top five states in the nation with respect to usage for the seven remaining months under study.

Focusing more specifically on utilization trends among physicians, 342 physicians, or 3% of all Illinois physicians, utilized the system at least once during the study period. Of these, 16% called on more than one occasion.

Given that 911 tapes were heard by Illinois physicians, an average of 2.6 tapes were requested per call. The number of tapes heard in the course of any one call ranged from 1 to 17.

An analysis of the number of tapes requested according to county (Table 3) indicated a wide geographic distribution. Relative to the number of practicing physicians, proportionately more tapes were heard and more physicians utilized the service outside of Cook County (Table 4).

**Table 4**  
**Utilization of the Dial Access System by Practice Location**

	Cook County	Illinois Outside Cook County
% of all practicing physicians	61	39
% of physicians using the Dial Access System	48	52
% of all tapes heard by physicians	51	49

The median proportion of physician utilizers to physicians in practice for the 50 counties using the service during the study period was .04611. Based on this figure, twelve of the 50 counties represented were identified as being in the top

**Table 5**  
**Characteristics of Counties in which the Proportion of Physicians using Dial Access was in top 25th Percentile**

County	Proportion of Physician Callers to those in Practice*	Total Number of Practicing Physicians	Total Number of Hospital Beds**	Hospitals with Medical School Affiliations	Total Population***
Clay	.14286	7	48	none	15,100
Clinton	.18182	11	103	none	29,400
Jo Daviess	.12500	8	65	none	22,100
Lawrence	.10000	10	65	none	17,200
Marshall	.11111	9	0	none	13,100
Mason	.16667	6	42	none	18,000
Massac	.66667	3	69	none	13,700
Mercer	.16667	6	63	none	17,300
Ogle	.20000	15	44	none	42,400
Richland	.19048	21	150	none	17,200
Union	.14286	7	48	none	16,000
White	.25000	8	57	none	13,700

\*Source: Illinois State Medical Society, Physician Members, 1976.

\*\*Source: American Hospital Association Guide to the Health Care Field, American Hospital Association, Chicago, Illinois, 1978.

\*\*\*Source: Vital Statistics Illinois, Springfield, Illinois, 1975.

**Table 6**  
**Tapes Most Frequently Selected By Physicians—By Title (A Rank Order of the Top Five) (N=911)**

Title of Tape	Number of Hearings	Rank Order
Chemotherapy of Breast Cancer	26	1
Treatment of Metastatic Cancer of the Prostate	22	2
Chemotherapy of Colorectal Cancer	22	2
The Question of Adjuvant Chemotherapy for Breast Cancer	21	3
Chemo-immunotherapy of Melanoma	14	4
Chemotherapy of Advanced Bronchogenic Carcinoma	14	4
Renal Carcinoma-Medical and Hormonal Therapy	14	4
Ovarian Cancer	13	5



Table 7

**Frequency of Selection of Tapes by Physicians—  
By Site  
(N=911)**

Bladder	15
Bone	10
Breast	153
Central Nervous System	30
Cervix	15
Colon/Rectum	56
Endometrium	22
Esophagus	11
Eye	5
Head/Neck	31
Hodgkin's Disease	14
Kidney	31
Leukemia	26
Liver	12
Lung	58
Melanoma	54
Multiple Myeloma	18
Non-Hodgkin's Lymphoma	20
Female Genital (other)	19
Male Genital (other)	4
Ovary	15
Pancreas	9
Prostate	36
Skin	5
Small Intestine	2
Soft Tissue Sarcomas	30
Stomach	13
Testes	22
Thyroid	37
Uterus	6
Unknown	7
Pituitary	5
Parathyroid	1
Parotid	2
Non-Site Specific	117

25th percentile with regard to utilization. An analysis of selected factors thought to be related to the proportionately higher utilization within these twelve counties, revealed that each of these counties have few practicing physicians (<25), few hospital beds (<200), and relatively small populations (<45,000). In addition, none of the twelve counties have any hospitals with medical school affiliations (Table 5).

An analysis of the frequency with which particular tapes were requested is shown in Table 6. The most requested tapes clearly reflect the desire to learn about chemotherapeutic strategies for specific cancers, particularly the most common ones seen by practitioners. On the other hand, of the 350 listings, 83% were heard at least once, indicating the diversified interests of physicians.

Categorized according to primary site rather than topic, the tapes on cancer of the breast, lung, bowel, skin, thyroid, and prostate were requested most frequently (Table 7).

## Discussion

The analysis of the data suggests that there is a greater need for cancer education outside of the metropolitan Chicago area and particularly among professionals at a distance from a concentration of health facilities and educational opportunities, formal and informal. This notion is compatible to some extent with previous studies of the Dial Access System. In 1973, Hickey, *et al.*, found that 35% of users were in solo practice<sup>2</sup> which was confirmed in 1976 by Tashima and Hickey.<sup>3</sup>

The frequency of tapes requested concerning chemotherapy may reflect the wealth of attention given in the professional and lay media to the advances of this cancer treatment modality, and particularly for breast neoplasms.

Attendance at conferences, symposia, and grand rounds may at times be difficult or informational resources unavailable. It may also be surmised that the conscientious physician, concerned about the complexity of the latest therapeutic strategies and schedules, might wish to re-affirm pre-existing knowledge through rapid contact with the most up-to-date source of information. This approach may be particularly valuable for the isolated practitioner who finds other information sources accessible only with difficulty.

New means for acquiring knowledge and effecting technological transfer need to be continually tested and evaluated. Education by means of the telephone, as exemplified by the Dial Access System, serves as a convenient means for conveying timely and concise information on the latest diagnostic and therapeutic approaches to the management of neoplastic disease. This analysis demonstrates that practicing physicians have a learning need in specific modalities of cancer management. These findings are not only useful as a means of evaluating the Dial Access Service, but may also be valuable in developing new educational strategies targeted to physicians.

## Acknowledgement

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## References

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2. Hickey, R. C. *et al.*: "Telephone Consultation—Dial Access: A Project in Cancer Education and Control," *Southern Med. J.* 66(10): 1159-1162, 1973.
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## License Renewal

# The Good News and the Bad

The bad news, you all know: To renew your medical license in 1980, you must have earned 100 hours of CME credit between April 1, 1978, and March 31, 1980.

The good news takes a bit longer to report:

1) The overwhelming majority of Illinois physicians comply with the CME requirements through their normal ongoing learning activities. Some studies of physician learning habits indicate that MD's spend three to five hours *a week* in documented CME. A recent analysis of California physicians showed they earned a *median* of 70 hours of Category 1 credit during 1978.

2) You need *not* submit a list of CME activities for which you earned credit. Illinois regulations provide only that you check "Yes" or "No" on the license-renewal form to indicate that you have (or have not) satisfied the regulations. (Note, however: Those regulations provide that the Department of Registration & Education may check physicians' records to verify that "Yes." While not finally settled, the Department is considering a verification plan that would ask a small percentage of physicians to submit a list of CME activities along with the 1980 renewal form.)

3) Only 20 hours credit must be earned from formal instructional programs (Category 1-a). The other 80 hours may be earned through (a) *teaching* in accredited medical schools, residency programs, and CME programs, and/or (b) participation in *patient care evaluation* in a licensed hospital or PSRO or local foundation. Alternatively, you can earn the full 100 hours in formal instructional programs. IN SUM: The Illinois requirements are flexible enough to fit the habits of almost every physician, practicing or academic.

### "Category 1"—Whose Definition?

Because of differences in wording, there's some confusion about Category 1 credit. The Illinois regulations call it "Category 1-a, Formal Programs." The AMA "Physician's Recognition Award" uses "Category 1, *Planned Program*." Despite differences in wording, they're the same.

### Any Questions?

If you're not sure where you stand, ask for a copy of the Illinois CME regulations. To obtain the regulations, or if you have specific questions about how they affect your particular situation, write or call: Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago, IL 60603 (312/236-6110). ◀

## Pulse

(Continued from page 144)

rise. In 1978, the rate was nearly fifteen deaths per 100,000, a three-fold increase.

However, overall cigaret smoking continues to *decline*, which is encouraging. About 32% of adults smoked last year, according to Dr. Richmond, but smoking is declining more rapidly among men than among women. Unfortunately, these statistics do not show a comparable pattern among young women and teenagers. Working with our teenagers is an area where we as physicians and physicians' spouses can be very effective. American teenagers should know the risks and effects of tobacco use. It is most important that young women be reached in the light of the new and frightening statistics on birth defects and possible adverse effects on growth and intellectual development of children.

For smokers, the question is not *whether* to quit, but *how*. As a former smoker—or should I say recovering smoker—I claim some expertise in this area. After all, the 1964 Surgeon General's report sat on my coffee table for thirteen years before it had a personal impact. Anyway, it can be done! The Madison Avenue image of the macho man with a cigarette, or the *soignée*, elegant woman puffing gracefully, is rapidly fading. It's fashionable now *not* to smoke. That makes it easier to quit. I don't think that anyone ever said that quitting smoking would be easy. I personally espouse the "cold turkey" method, but many people have found a "cut down/cut out" plan effective. An Indiana auxiliary member, Margaret Nolan, writing for *The Hoosier Doctor's Wife*, offers these tips—some of which may work, others not. Try switching brands, then none. Carry and chew sugarless gum. Tell everyone that you've quit; you won't want to "backslide." Join or organize a Quit-Smoking group. Take up a sport. Seek professional help if necessary. Start working on a Master's thesis or some other major project. Diet first before you quit. And the final tip, "If at first you don't succeed, quit, quit, and quit again."

Just think of the advantages—if you stop smoking! Room in your pockets or purse. Money in the same. No more nicotine fits or frantic searches for elusive cigarettes. A beautiful white smile. Long, tapered, non stained fingers. Hearing "Gee, your hair smells terrific," applied to you. No more Air Wick in the closet. Clean ashtrays. Hole free clothing, furniture and rugs. Lower fire and health insurance premiums. Pink lungs and extra years of a happy, healthy life. Best of all, freedom—and a new self respect.

Cheers! Inhale and farewell. ◀



# Convention Handbook



## ANNUAL MEETING '80

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Delegates and Alternate Delegates to the Illinois State  
Medical Society

Officers of County Medical Societies

Agenda of the House of Delegates

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Program Summary By Days

ISMS Auxiliary Convention Program

Resolutions

*The Illinois State Medical Society*

*cordially invites you to a gala*

*President's Night*

*Dinner Dance*

*April 15, 1980*

*honoring*

P. John Seward, M.D.

President

Illinois State Medical Society

*Featuring*

*The Mike Pizzuto Trio*

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	J. Stroyls	C. G. Glen	SBS	Ronald Meyer	Victor Jay
			RPS	David Whitney	Ronald Davis
				William E. Golden	David Olive



## Cook County Delegates

<i>Delegates</i>	<i>Alternate Delegates</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
Aaronson, Donald Andelman, Samuel L. Andersen, James H. Bartolome, Juanito Berg, Max Bhorade, Maruti S. Blankshain, Richard Bogen, Gilbert Bragman, Robert Brislen, Andrew J. Brown, Finley W., Jr. Budrys, Stanley	Ahstrom, James, Jr. Armstrong, Claressa Banuchi, Fedor F. Beck, Charles A. Bellows, Randall Bild, Sidney Borelli, Nelson Branovacki, Eugene Brown, Murray C. Budrys, Milda Burdick, Allison L., Jr. Burdick, Allison L., Sr.	Meisenheimer, Martin P. Murray, Meredith B. Nemecek, Raymond W. Neskodny, J. F. Odiaga-Garcia, Ignacio Okner, Henry B. Olivar, Adriano Ostrowski, Fabian Panayotou, Irene Patlak, Erwin M. Perritt, Richard Peterson, Arthur R.	O'Sullivan, Donald D. Palmer, Arthur Pamintuan, Rodolfo L. Panton, John H. Pantone, Anton M. Pill, Michael P. Podzamsky, George Poma, Pedro A. Prombo, Marjorie P. Pustelnikas, Anthony Rebendel, Marek B. Richardson, James M.
Burkhead, Howard C. Ciskoski, Ronald J. Costanzo, Vincent A. Cross, Roland R. Czeisler, Tibor DeYoung, Willard Diffenbaugh, W. G. Falloon, Edwin L. Farah, George S. Filipowicz, Roman I. Fischer, Arthur Fish, William	Callaway, Lloyd Carroll, Catherine G. Cermak, Miles Chaljub, Najib Christensen, Eldis M. Coleman, John M. Constantaras, Alexander Cornbleet, David H. Cucco, Ulisse P. Danckers, Ulrich DeJong, George A. DiMarco, Eugene R.	Petty, David T. Quinlan, Donald Razim, Edward A. Rice, C. Malcolm, Jr. Romanus, Raymond J. Rothstein, David A. Roy, Shirley Ruane, Michael Ruzich, Stanley Saulys, Vacys Saxena, Virendra S. Schifano, Joseph	Ricker, Alfred P. Rodriguez, Ignacio Saltiel, Isaac Santos, Antonio Sarley, Vincent Saulys, Augusta Z. Schall, Samuel M. Schuetz, John N. Schwartz, Malcolm Seed, Randolph Seglin, Melvin N. Short, Marshall
FitzGibbons, James P. Flaherty, B. P. Flanagan, C. Larkin Frankel, Jerome J. Freda, Vincent C. Gertz, George Goldstein, Henry Gonzales, Martin Green, Martin W. Guerrero, Severo K., Jr. Hamilton, Robert C. Harrod, John	De Trana, Frank A. Diaz, Alfonso Elegant, Lawrence D. Fagan, Peter T. Forgione, Hebe M. Forkosh, David Gianasi, Charles Gnade, Gerard R. Goodman, Harold Graham, James Greville, Warwick Handler, Jerome L.	Schimel, Samuel J. Sedlak, Frank Shapiro, Maynard I. Shaw, Richard Shobris, Martin Simon, Arnold Sinaiko, Edwin S. Smith, C. Otis Soboroff, Burton J. Solon, Earl U. Sperling, Richard L. Springer, Harry	Siedentop, Karl H. Siedlinski, John Strohl, Lee H. Sultan, Thomas R. Sutoris, Edward D. Talso, Peter J. Thampy, Kishore J. Tsatsos, George Varzino, Louis Vargas, Eladio A. Vega, Jesus Yon, Mustafa
Hinkamp, Joseph F. Hoban, Eugene Hoeltgen, Maurice Horton, Loren B. Hrejsa, Allen C. Hutchison, William A. Hyde, John S. Jaffe, Harry J. Jensen, Harold Jirka, Frank J., Jr. Joslyn, A. Everett, Jr. Kahn, Sidney C.	Henry, Harvey John, Thomas Johnson, M. Anita Jones, Richard Kass, Harold M. Knudson, John A. Konecny, Philip Landau, Richard L. Lipsich, Michael Lucina, Pedro A. McCabe, Mary Joan Meccia, Donald	Staley, Warren H. Steinitz, Franz S. Suckow, Earl E. Sugar, Sam J. Swartz, Robert M. Tansey, William J. Tekdogan, Mehmet M. Thompson, J. Robert Tovar, Jorge Treister, Michael R. Ungar, Jacob Walkowiak, Lydia	Zitek, Russell W. Zurita, Victor
Kalsch, Harry E. Kaz, Alex H. Kirschenbaum, M. Barry Kobak, Mathew Kowal, Roland A. Kwinn, Frank C. Lagorio, George L. Libman, Robert H. Lobraico, Rocco V., Jr. Lukaszewski, Edwin J. MacNerland, Robert H. Marshall, William	Meyenberg, John Mikhail, Kamel A. Mohr, Dorothy P. Muehrcke, Robert C. Munoz, Maria Muriel, Hugo H. Murphy, Thomas E. Mustell, Robert R. Neuman, Helen A. Nikurs, Lydia Nourbakhsh, M. Nosal, Roger	Wehrmacher, Wm. H. Weigel, Charles J. Williams, Jack Xydakis, Stephanos A.	

# Officers of County Medical Societies

## 1980

COUNTY	PRESIDENT	SECRETARY
<b>ADAMS</b> Members: 105-Dist. 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	<b>Julio Del Castillo</b> 1124 Broadway, Quincy 62301	<b>Richard L. Newman</b> 1124 Broadway, Quincy 62301
<b>ALEXANDER</b> Members: 6-Dist. 9	<b>Gemo Wong</b> 529 Cross, Cairo 62914	<b>Charles L. Yarbrough</b> 800 Commercial, Cairo 62914
<b>BOND</b> Members: 10-Dist. 7	<b>John K. Dawdy</b> 100 N. Locust, Greenville 62246	<b>Thomas D. Dawdy</b> 100 N. Locust, Greenville 62246
<b>BOONE</b> Members: 18-Dist. 12	<b>Miladen Mijanovich</b> 556 E. Grant, Marengo 60152	<b>John Steinkamp</b> 824 S. Van Buren, Belvidere 61008
<b>BUREAU</b> Members: 36-Dist. 2	<b>Ruben Santos</b> 601 E. 1st St., Spring Valley 61362	<b>Swaski Pothikamjorn</b> 1030 W. 4th St., Spring Valley 61362
<b>CARROLL</b> Members: 8-Dist. 12	<b>Eliseo M. Colli</b> 102 E. Washington, Mt. Carroll 61053	<b>Benjamin Sy</b> Savanna Medical Center, Savanna 61074
<b>CASS-BROWN</b> Members: 2-Dist. 6		
<b>CHAMPAIGN</b> Members: 225-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	<b>James C. Nauman</b> 401 E. Springfield, Champaign 61820	<b>H. Ewing Wachter</b> 805 W. Kirby, Champaign 61820
<b>CHRISTIAN</b> Members: 26-Dist. 7	<b>Muhammad T. Salaymeh</b> P.O. Box 322, Taylorville 62568	<b>I. Del Valle</b> 311 S. Main, Taylorville 62568
<b>CLARK</b> Members: 5-Dist. 8	<b>Howard G. Johnson</b> P.O. Box 68, Casey 62420	<b>Eugene P. Johnson</b> P.O. Box 68, Casey 62420
<b>CLAY</b> Members: 7-Dist. 7	<b>Donald L. Bunnell</b> Flora Clinic, Flora 62839	<b>Eugene Foss</b> P.O. Box 250, Flora 62839
<b>CLINTON</b> Members: 11-Dist. 7	<b>Jose R. Sosa</b> Munster St., Germantown 62245	<b>James A. Kirby</b> 401 N. Main, Breese 62230
<b>COLES-CUMBERLAND</b> Members: 45-Dist. 8	<b>Albert Schubert, Jr.</b> 720 4th St., Charleston 61920	<b>Asit P. Basu</b> 921 18th St., Charleston 61920
<b>COOK</b> Members: 8648-Dist. 3 Robert Lindley, Ex. Dir. 310 S. Michigan Ave. Chicago 60604	<b>Lawrence L. Hirsch</b> 2434 Grace, Chicago 60618	<b>Alfred J. Clementi</b> 675 W. Central Rd., Arlington Hts. 60005
<b>CRAWFORD</b> Members: 15-Dist. 8	<b>Michael W. Elliott</b> Family Practice Clinic, Robinson 62454	<b>W. B. Schmidt</b> Schmidt Clinic, Robinson 62454
<b>DE KALB</b> Members: 61-Dist. 12	<b>Darrell B. Wiley</b> 232 S. Second, DeKalb 60115	<b>William F. Stach</b> 407 W. State St., Sycamore 60178
<b>DE WITT</b> Members: 11-Dist. 5	<b>John W. Veirs</b> 219 E. Main, Clinton 61727	<b>C. N. Radhakrishna</b> 210 E. Main, Clinton 61727
<b>DOUGLAS</b> Members: 8-Dist. 8	<b>Grant A. Jones</b> 318 S. Ash, Arthur 61911	<b>Humberto Mondul</b> 111 W. South Central, Tuscola 61953
<b>DU PAGE</b> Members: 616-Dist. 11 Lillian Widmer, Ex. Sec. 26 W. St. Charles Rd. Lombard, IL 60148	<b>Vernon Bartley</b> 223 N. York, Elmhurst 60126	<b>James P. Campbell</b> 322 N. Blanchard St., Wheaton 60187



COUNTY	PRESIDENT	SECRETARY
<b>EDGAR</b> Members: 16-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
<b>EFFINGHAM</b> Members: 20-Dist. 7	Fabio H. Mota 300 N. Maple, Effingham 62401	Robert Farmer St. Anthony Memorial Hospital, Effingham 62401
<b>FAYETTE</b> Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 800 N. Eighth St., Vandalia 62471
<b>FORD</b> Members: 11-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
<b>FRANKLIN</b> Members: 26-Dist. 9	James P. Durham Benton Med. Clinic, Benton 62812	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
<b>FULTON</b> Members: 37-Dist. 4	Marcus A. Quinones 175 S. Main, Canton 61520	Jesse M. Reyes 210 W. Walnut, Canton 61520
<b>GALLATIN</b> Members: 2-Dist. 9		John E. Doyle Ridgway 62979
<b>GREENE</b> Members: 7-Dist. 6	Gary L. Turpin 712 S. College, Greenfield 62044	James C. Reid 712 S. College, Greenfield 62044
<b>HANCOCK</b> Members: 11-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
<b>HENDERSON</b> Members: 2-Dist. 4	Farouk El Khatib Stronghurst Med. Cntr., Stronghurst 61480	Silvino Lindo, Jr. Biggsville 61418
<b>HENRY-STARK</b> Members: 38-Dist. 4	James C. Parsons 648 N. Chicago, Geneseo 61254	Myrna Parungao 625 Page, Kewanee 61443
<b>IROQUOIS</b> Members: 22-Dist. 11	Bela Borsos 207 N. Axtel, Milford 60953	Leslie C. Duis 845 S. 4th, Watseka 60970
<b>JACKSON</b> Members: 71-Dist. 9	Myron T. Potter Box 2347, Carbondale 62901	Kevin K. Mooney 404 W. Main St., Carbondale 62901
<b>JASPER</b> Members: 2-Dist. 8	Juan J. Serra 507 W. Washington, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
<b>JEFFERSON-HAMILTON</b> Members: 33-Dist. 9	Nabil L. Messiha 3454 Broadway, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
<b>JERSEY-CALHOUN</b> Members: 11-Dist. 6	Clyde Wieland McDow Med. Cntr., Maple Summit Rd., Jerseyville 62052	S. S. Kurella McDow Med. Ctr., Maple Summit Rd., Jerseyville 62052
<b>JO DAVIESS</b> Members: 8-Dist. 12	David Hockman 300 Summit St., Galena 61036	Wilbur Johnson 300 Summit St., Galena 61036
<b>KANE</b> Members: 305-Dist. 1 Michael Wild, Ex. Dir. 202 Campbell Geneva 60134	James Downing 157 S. Lincoln, Aurora 60505	John A. O'Dwyer 34 N. Water, Batavia 60510
<b>KANKAKEE</b> Members: 107-Dist. 11	Donald Parkhurst 401 N. Wall, Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
<b>KENDALL</b> Members: 7-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
<b>KNOX</b> Members: 74-Dist. 4	Arthur C. Watson 575 N. Kellogg St., Galesburg 61401	J. John Loesch 695 N. Kellogg, Galesburg 61401
<b>LAKE</b> Members: 387-Dist. 1 Julia Schulz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	Albino Bismonte 135 N. Greenleaf, Gurnee 60031	J. Vickers Brown 1160 Park Ave. W., Highland Park 60035

COUNTY	PRESIDENT	SECRETARY
<b>LA SALLE</b> Members: 113-Dist. 2	Don Morehead 313 W. Madison, Ottawa 61350	Allan L. Goslin 712 N. Bloomington, Streator 61364
<b>LAWRENCE</b> Members: 10-Dist. 8 Ruth Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Francisco E. Martin 542 N. Main, Bridgeport 62417
<b>LEE</b> Members: 29-Dist. 12	Wilbur L. Stitzel KSB Hosp., 403 E. First St., Dixon 61021	Joseph Elie 120 S. Hennepin, Dixon 61021
<b>LIVINGSTON</b> Members: 28-Dist. 2	Roger K. Kipfer 109 W. Howard St., Pontiac 61764	Karl T. Deterding 612 E. Water, Pontiac 61764
<b>LOGAN</b> Members: 24-Dist. 5	Edward Ulrich 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
<b>MACON</b> Members: 159-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	M. Joseph Schrodt 363 S. Main, Decatur 62523	H. L. Wibbels 2300 N. Edward, Decatur 62526
<b>MACOUPIN</b> Members: 21-Dist. 6	John Ubben Community Mem. Hosp., Staunton 62088	Robert England 224 E. Main, Carlinville 62626
<b>MADISON</b> Members: 188-Dist. 6	Francisco Dioneda 2044 Madison, Granite City 62040	Norman E. Taylor 95 S. 9th St., E. Alton 62024
<b>MARION</b> Members: 40-Dist. 7	Jerome H. Brodish 407 N. Pleasant, Centralia 62801	W. P. Plassman Box 552, Centralia 62801
<b>MARSHALL-PUTNAM</b> Members: 8-Dist. 2	Joe W. Cannon 202 S. Main, Lacon 61540	Donald M. Gallagher Box 538, Granville, 61326
<b>MASON</b> Members: 6-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	
<b>MASSAC</b> Members 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
<b>MCDONOUGH</b> Members: 34-Dist. 4	Stephan Roth Colchester 62326	David Reem 505 E. Grant, Macomb 61455
<b>McHENRY</b> Members: 79-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098		James H. Mowery 1110 N. Green St., McHenry 60050
<b>McLEAN</b> Members: 123-Dist. 5 Bernyce Carbery Exec. Sec. 401 W. Virginia Normal 61761	Albert F. Cunningham 900 Franklin, Normal 61761	John R. Krueger #1 Medical Hills Dr., Bloomington 61701
<b>MERCER</b> Members: 6-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	
<b>MONROE</b> Members: 10-Dist. 10	Edilberto F. Maglasang 109 W. Legion, Columbia 62236	Chung H. Khan Box 142, Lakeview Dr., Waterloo, 62298
<b>MONTGOMERY</b> Members: 21-Dist. 5	L. George Allen 400 Monroe, Litchfield 62056	James T. Foster 8 Arrowhead Rd., Litchfield 62056
<b>MORGAN-SCOTT</b> Members: 49-Dist. 6	Charles Wilson 814 W. State St., Jacksonville 62650	Eric Giebelhausen 1600 W. Walnut, Jacksonville 62650
<b>MOULTRIE</b> Members: 5-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951



COUNTY	PRESIDENT	SECRETARY
<b>OGLE</b> Members: 15-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
<b>PEORIA</b> Members: 363-Dist. 4 M. John Hanni, Jr., Ex. Sec. 427 1st National Bank Peoria 61602	Henry Boldt 427 1st Nat'l. Bank Bld., Peoria 61602	Frederick Heinzen 427 1st Nat'l. Bank Bld., Peoria 61602
<b>PERRY</b> Members: 14-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
<b>PIATT</b> Members: 4-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
<b>PIKE</b> Members: 10-Dist. 6	Carlos B. Lara 326 W. Washington, Pittsfield 62363	T. C. Bunting 321 W. Washington, Pittsfield 62363
<b>PULASKI</b> Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
<b>RANDOLPH</b> Members: 22-Dist. 10	Stephen M. Platt 1101 George St., Chester 62233	J. M. Whittenberg 1650 State St., Chester 62233
<b>RICHLAND</b> Members: 23-Dist. 8	Paul C. Weber 1200 N. East, Olney 62450	Arcot D. Suresh 1200 N. East St., Olney 62450
<b>ROCK ISLAND</b> Members: 203-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	William Dougherty 4602 3rd St., Moline 61265	Miguel Flores 532 19th, Moline 61265
<b>ST. CLAIR</b> Members: 261-Dist. 10 Ed Belz, Ex. Sec. 4825 W. Main Belleville 62223	H. Frank Holman Oliver Anderson Hosp., Maryville 62062	Robert C. Wanless 6401 W. Main, Belleville 62223
<b>SALINE-POPE-HARDIN</b> Members: 33-Dist. 9	William B. Skaggs 203 N. Vine, Harrisburg 62946	Warren R. Dammers P.O. Box 281, Harrisburg 62946
<b>SANGAMON</b> Members: 327-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza Springfield 62701	Jess Diamond 701 N. Walnut, Springfield 62702	Towfig Arjmand 1307 S. 7th St., Springfield 62703
<b>SCHUYLER</b> Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
<b>SHELBY</b> Members: 9-Dist. 7	Theodore Little 207 S. Pine, Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
<b>STEPHENSON</b> Members: 54-Dist. 12	James McGath 1815 W. Church, Freeport 61032	George Laeen 1045 W. Stephenson, Freeport 61032
<b>TAZEWELL</b> Members: 66-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Terry Tosi P.O. Box 778, Pekin 61554	Robert F. Gregorski P.O. Box 778, Pekin 61554
<b>UNION</b> Members: 6-Dist. 9	Thomas W. Davis 200 N. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Anna 62906
<b>VERMILION</b> Members: 103-Dist. 8	Angelo Anaclerio 1104 N. Vermilion, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
<b>WABASH</b> Members: 6-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863

COUNTY	PRESIDENT	SECRETARY
WARREN Members: 14-Dist. 4	Richard Icenogle Box 188, Roseville 61473	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 9-Dist. 10	Ralph Kelly 113 W. St. Louis, Nashville 62231	Methee Vanadilok 111 S. Washington, Nashville 62263
WAYNE Members: 9-Dist. 9	Charles J. Jannings 101 E. Center, Fairfield 62837	Arthur R. Marks 101 E. Center St., Fairfield 62837
WHITE Members: 7-Dist. 9	John Stricklin West Main St., Carmi 62891	Julius Harrell Doctor's Clinic, Carmi 62821
WHITESIDE Members: 55-Dist. 12	Richard A. Londo 204 N. Jackson, Morrison 61270	Reda Salama 1714 Gregden Shores, Sterling 61081
WILL-GRUNDY Members: 230-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	John W. Bowden 330 Madison, Joliet 60435	Robert G. Olsen 120 Scott, Joliet 60431
WILLIAMSON Members: 36-Dist. 9	Robert Kane 120 W. Walnut, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
WINNEBAGO Robert Carlson Act. Exec. Adm. Members: 408-Dist. 12 310 N. Wyman St. Rockford 61101	Richard S. Webb, Jr. 2500 N. Rockton, Rockford 61103	Bernard O'Malley 5670 E. State St., Rockford 61108
WOODFORD Members: 7-Dist. 2	Joseph C. Phifer 203 S. Main, Eureka 61530	James W. Riley 109 S. Major, Eureka 61530
No Organized County Society		Joint County Societies
Edwards		Cass-Brown
Johnson		Marshall-Putnam
Menard		Coles-Cumberland
		Morgan-Scott
		Henry-Stark
		Saline-Pope-Hardin
		Jefferson-Hamilton
		Will-Grundy
		Jersey-Calhoun

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference issue (October). Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: (      ) \_\_\_\_\_

COUNTY MEDICAL SOCIETY: \_\_\_\_\_

MEDICAL SPECIALTY AND TYPE OF PRACTICE: \_\_\_\_\_

COMMITTEE IN WHICH INTERESTED: \_\_\_\_\_

EXPERTISE FOR THIS COMMITTEE: \_\_\_\_\_

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society  
55 E. Monroe, Suite 3510, Chicago, IL 60603



# *Agenda*

## *1980 House of Delegates*

Robert P. Johnson, M.D., *Speaker*

Clifton L. Reeder, M.D., *Vice-Speaker*

### **FIRST SESSION**

**10:30 a.m.—Sunday, April 13, 1980**

**Great Hall**

**Pick Congress**

**Chicago**

1. Call to order  
Robert P. Johnson, M.D., *Speaker*
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Approval of minutes of previous meeting
6. Memorial Service for deceased members since May, 1979 conducted by Audley F. Conner, Jr., M.D.,  
*Secretary-Treasurer*
7. Report of Chairman, Board of Trustees  
Robert R. Hartman, M.D.
8. Remarks of Speaker
9. Resolutions and supplementary reports
10. New business and announcements  
Reference Committees—2:00 p.m.  
Delegates' Buffet—6:00 p.m.
11. Recess until 2:30 p.m.—Monday, April 14, 1980

### **SECOND SESSION**

**2:30 p.m.—Monday, April 14, 1980**

**Great Hall**

**Pick Congress**

**Chicago**

1. Call to order by speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Reports of special guests  
Mrs. R. Samuel Hoover, *President*, Illinois State Medical Society Auxiliary  
Mrs. Cissy Egley, *President*, Illinois Society, American Association of Medical Assistants
5. Introduction of special guests
6. Presentation of certificates of appreciation to Continuing Medical Education Examiners
7. Presentation of AMA-ERF check to Illinois medical schools
8. IMPAC Report  
Herbert Sohn, M.D., *Chairman*
9. Report of Executive Administrator  
Mr. Roger N. White
10. Introduction of AMA Delegates and Alternate Delegates  
Herschel Browns, M.D., *Chairman*
11. President's Address  
P. John Seward, M.D.
12. New business and announcements
13. Recess until 9:00 a.m.—Tuesday, April 15, 1980

### THIRD SESSION

9:00 a.m.—Tuesday, April 15, 1980

Great Hall  
Pick Congress  
Chicago

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| <ol style="list-style-type: none"> <li>1. Call to order by the speaker</li> <li>2. Invocation</li> <li>3. Report of Committee on Rules and Order of Business</li> <li>4. Report of Credentials Committee</li> <li>5. Announcements and introduction of guests</li> <li>6. Reports of Reference Committees <ul style="list-style-type: none"> <li>Amendments to Constitution and Bylaws</li> <li>Committee A—Officers, Administration, Finances and Budgets</li> <li>Committee B—Government Health Programs, including National Health Insurance and Cost Containment</li> </ul> </li> </ol> | <ol style="list-style-type: none"> <li>Committee C—Education, Manpower and Clinical Medicine</li> <li>Committee D—Medical Service and Economic Matters Outside of Government Programs</li> <li>Committee E—Governmental Affairs and Medical Legal</li> <li>Committee F—Public Relations, Membership and Miscellaneous Business</li> <li>7. Recess for luncheon</li> <li>8. Reconvene 2:00 p.m.</li> <li>9. New Business</li> <li>10. Recess until 9:00 a.m.—Wednesday, April 16, 1980</li> </ol> |
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### FOURTH SESSION

9:00 a.m.—Wednesday, April 16, 1980

Great Hall  
Pick Congress  
Chicago

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| <ol style="list-style-type: none"> <li>1. Call to order by the Speaker</li> <li>2. Invocation</li> <li>3. Report of Committee on Rules and Order of Business</li> <li>4. Report of Credentials Committee</li> <li>5. Induction of Herschel Browns, M.D., President-Elect into office of President by P. John Seward, M.D.</li> <li>6. Address of President Browns</li> <li>7. Announcements and introduction of guests</li> <li>8. Reports of reference committees</li> <li>9. Elections <ul style="list-style-type: none"> <li>Report of Nominating Committee <ul style="list-style-type: none"> <li>(a) President-Elect (DS)</li> <li>(b) 1st Vice President (CMS)</li> <li>(c) 2nd Vice President (DS)</li> <li>(d) Secretary-Treasurer</li> <li>(e) Speaker of the House (DS)</li> <li>(f) Vice Speaker (CMS)</li> <li>(g) Trustees</li> </ul> </li> </ul> </li> </ol> | <p>David S. Fox, M.D.<br/>Lawrence L. Hirsch, M.D.<br/>Joseph R. O'Donnell, M.D.<br/>John J. Ring, M.D.<br/>Charles K. Wells, M.D.<br/>George T. Wilkins, Jr., M.D.</p> <p>(i) Alternate Delegates to AMA to take office January 1, 1981, and serve until December 31, 1982</p> <p style="text-align: center;"><i>Terms Expiring</i></p> <p>Andrew J. Brislen, M.D.<br/>Alfred Clementi, M.D.<br/>Audley F. Connor, Jr., M.D.<br/>Morris T. Friedell, M.D.<br/>Robert P. Johnson, M.D.<br/>Eugene T. Leonard, M.D.<br/>Boyd McCracken, M.D.<br/>Clifton L. Reeder, M.D.</p> <p>(j) Rules and Order of Business to take office April 16, 1980 and to serve until May 20, 1981<br/>Ratification of members</p> <p>(k) Judicial Panel to take office April, 1980 and serve until April, 1985</p> <p style="text-align: center;"><i>Terms Expiring</i></p> <p>J. Robert Thompson, M.D.</p> |
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| <p><i>DISTRICT</i></p> <p>Second Allan L. Goslin, M.D.<br/>Third Raymond J. DesRosiers, M.D.<br/>Third Harold J. Lasky, M.D.<br/>Third Richard N. Rovner, M.D.<br/>Third Joseph C. Sherrick, M.D.<br/>Eleventh Kenneth A. Hurst, M.D.<br/>Twelfth Joseph Perez, M.D.</p> <p>(h) Delegates to AMA to take office January 1, 1981, and serve until December 31, 1982</p> <p style="text-align: center;"><i>Terms Expiring</i></p> <p>Allison L. Burdick, Jr., M.D.<br/>Henrietta Herbolzheimer, M.D.</p> | <ol style="list-style-type: none"> <li>10. Fixing of per capita dues for 1981</li> <li>11. Selection of meeting place and time for next meeting</li> <li>12. Unfinished business</li> <li>13. New business</li> <li>14. Adjournment, Sine Die</li> </ol> |
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# **Committees of the House of Delegates**

## **1980 Annual Meeting**

### **COMMITTEE ON RULES & ORDER OF BUSINESS**

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

### **COMMITTEE ON CREDENTIALS**

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

### **TELLERS AND SERGEANTS AT ARMS**

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

### **REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS**

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

### **REFERENCE COMMITTEE A**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances and budgets.

### **REFERENCE COMMITTEE B**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including national health insurance and cost containment.

### **REFERENCE COMMITTEE C**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower and clinical medicine.

### **REFERENCE COMMITTEE D**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical service and economic matters outside government programs.

### **REFERENCE COMMITTEE E**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to governmental affairs and medical legal matters.

### **REFERENCE COMMITTEE F**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations, membership and miscellaneous business.

# Program Summary By Days

## ISMS Annual Meeting

**April 13-16, 1980**

**Pick Congress, Chicago**

### **Saturday, April 12, 1980**

- 8:30 a.m.** Resident Physicians Section
- 9:00 a.m.** Board of Trustees Meeting
- 1:00 p.m.** Student Business Session
- 1:00 p.m.** Alcohol and Substance Abuse Seminar

- 2:00 p.m.** Credentials Committee
- 2:30 p.m.** House of Delegates
- 5:00 p.m.** Downstate Caucus
- 5:00 p.m.** C.M.S. Caucus
- 7:30 p.m.** Medical-Legal Program

### **Sunday, April 13, 1980**

- 7:30 a.m.** Preventive Medicine Breakfast
- 8:00 a.m.** Registration
- 9:30 a.m.** Meeting of Reference Committee Members
- 10:00 a.m.** Credentials Committee
- 10:30 a.m.** House of Delegates
- 11:30 a.m.** IMPAC Annual Meeting
- 11:45 a.m.** District Meetings
- 2:00 p.m.** Reference Committees
- 6:00 p.m.** Delegates Buffet

### **Tuesday, April 15, 1980**

- 7:30 a.m.** CIMA Breakfast
- 7:30 a.m.** Board of Trustees Meeting
- 8:00 a.m.** Registration
- 9:30 a.m.** Credentials Committee
- 10:00 a.m.** House of Delegates
- 12:00 noon** Recess
- 2:00 p.m.** House of Delegates
- 6:00 p.m.** President's Reception and Dinner

### **Monday, April 14, 1980**

- 7:30 a.m.** ISMS-IMPAC Public Affairs Breakfast
- 8:00 a.m.** Registration
- 12:00 noon** ICCME Workshop
- 12:00 noon** Fifty Year Club
- 1:00 p.m.** ISMIE Membership Meeting
- 2:00 p.m.** ISMIE Board Meeting

### **Wednesday, April 16, 1980**

- 7:30 a.m.** CIMA Breakfast
- 7:30 a.m.** Board of Trustees Meeting
- 8:00 a.m.** Registration
- 8:30 a.m.** Credentials Committee
- 9:00 a.m.** House of Delegates
- Board of Trustees Reorganization Meeting**  
immediately following House adjournment



# ISMS DELEGATION TO THE AMA

## Delegates

*To serve from Jan. 1, 1979 to Dec. 31, 1980  
(Elected April 5, 1978)*

Allison L. Burdick, Jr., Chicago  
Henrietta Herbolzheimer, Chicago  
David S. Fox, Chicago  
Lawrence L. Hirsch, Chicago  
Joseph R. O'Donnell, Glen Ellyn  
John J. Ring, Mundelein  
Charles K. Wells, Mt. Vernon  
George T. Wilkins, Granite City

*To serve from Jan. 1, 1980 to December 31, 1981  
(Elected May 9, 1979)*

Herschel Browns, Chicago  
Howard C. Burkhead, Evanston  
Jack L. Gibbs, Canton  
Theodore Grevas, Rock Island  
Morgan M. Meyer, Lombard  
Maynard I. Shapiro, Chicago  
Joseph Skom, Chicago

## Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.  
Edwin S. Hamilton, Kankakee  
Frank J. Jirka, Jr., Barrington Hills  
Burtis E. Montgomery, Harrisburg

*Delegation Chairman: Herschel Browns; Secretary: Theodore Grevas*

## Alternate Delegates

*To serve from Jan. 1, 1979 to Dec. 31, 1980  
(Elected April 5, 1978)*

Andrew J. Brislen, Chicago  
Alfred Clementi, Arlington Heights  
Audley F. Connor, Jr., Chicago  
Morris T. Friedell, Chicago  
Robert P. Johnson, Springfield  
Eugene T. Leonard, Rockford  
Boyd McCracken, Greenville  
Clifton L. Reeder, Chicago

*To serve from January 1, 1980 to December 31, 1981  
(Elected May 9, 1979)*

Robert Hamilton, Chicago  
Robert R. Hartman, Jacksonville  
Eugene P. Johnson, Casey  
Lee Johnson, Litchfield  
Harold Lasky, Chicago  
Glen E. Tomlinson, Lincoln  
Cyril C. Wiggishoff, Chicago

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*The Public Affairs Committee of the ISMS  
cordially invites Physicians and Auxiliaries  
to a complimentary Public Affairs Breakfast  
on Monday, April 14, 1980, 7:30 a.m.,  
Gold Room,  
at the Pick Congress Hotel, Chicago*

*Tickets for the breakfast will be available at convention registration on a first come, first served basis.*

*For further information, please contact Geoff Obrzut at ISMS offices, 55 East Monroe, Suite 3510, Chicago 60603. Telephone (312) 782-1654.*

# ISMS Auxiliary

## Fifty-Second Annual Meeting

### Pick Congress, Chicago

#### Sunday, April 13, 1980

<b>Noon</b>	Pin & Gavel Luncheon (Past Presidents only) Mrs. Earl Klaren, hostess Honoring past state presidents and honorary members
<b>2-4 pm</b>	Registration
<b>3:00 pm</b>	Pre-Convention Board Meeting Board and out-of-state guests
<b>5:00 pm</b>	Reception honoring student spouses
<b>7:00 pm</b>	Board Dinner Spouses and guests welcome; cash bar Reception to follow dinner in hospitality suite Hospitality Chairman, hostess, members-at-large invited

#### Monday, April 14, 1980

<b>7:30 am</b>	ISMS Public Affairs Breakfast Tickets available at ISMS registration desk	<i>Gold Room</i>
<b>8:00 am</b>	Registration AMA-ERF Boutique opens; coffee and rolls	
<b>9:00 am</b>	Opening—House of Delegates Welcome and Response Pledge to the Flag and Auxiliary Pledge Announcements Introduction of special guests Greetings from ISMS officers	<i>Buckingham Room</i>
<b>10:30 am</b>	Introduction of Keynote Speaker: <i>Mrs. Edward Szewczyk</i> Keynote Address: <i>Mrs. John F. Vaughan</i> , President-elect, AMAA Medic Alert Mini-Presentation: <i>Ms. Addie Weinstein</i> Sports Medicine Program: "How to Play with 'itis'" <i>Dr. Clarence Fossier</i> , team physician, Chicago Bears	
<b>11:00 a.m.</b>		
<b>12:30 pm</b>	President's Luncheon Honoring past state presidents—guests invited Lake County Auxiliary, hostesses Program Speaker: <i>Ann Horn</i> , Indianapolis, Indiana	<i>Windsor Room</i>
<b>2:00 pm</b>	Second Session—House of Delegates Program—Physical Fitness Memorial Service	<i>Buckingham Room</i>
<b>7:00 pm</b>	Dinner on the Town	

#### Tuesday, April 15, 1980

### County Day

<b>8:00 am</b>	Registration AMA-ERF Boutique opens; coffee and rolls	
<b>9:30 am</b>	Third Session—House of Delegates Announcements Annual Awards Reports Presentation of Humanitarian Award	<i>Buckingham Room</i>
<b>1:00 pm</b>	Installation Luncheon Champaign County Auxiliary, hostesses Installation— <i>Mrs. Harlan Failor</i> , president New officers, directors and councilors Installing officer: <i>Mrs. John F. Vaughan</i> Presentation of President's Pin & Gavel President's acceptance speech— <i>Mrs. Harlan Failor</i> Program—Fashions for Fitness	<i>Windsor Room</i>
<b>3:30 pm</b>	Post-Convention Board Meeting	
<b>6:00 pm</b>	ISMS President's Night Reception and Dinner	<i>Gold Room</i>



Guest Speaker: Stanley Gitlow, M.D., New York

## Alcohol and Substance Abuse Triage and Treatment

Saturday, April 12, 1980

1:00 p.m.—5:00 p.m.

**Clinical Update: 1:00 p.m.**

Edward C. Senay, M.D., professor of psychiatry, University of Chicago Hospitals and Clinics, chief medical consultant, Illinois Dangerous Drugs Commission and chairman, ISMS Committee on Alcoholism and Drug Dependence. Dr. Senay has served as chief of the University of Chicago Psychiatric Consultation Service, director of the Illinois Drug Abuse Program and clinical director of Substance Abuse Services, Inc. Presently engaged in research to determine the efficacy of marijuana in alleviating side effects of chemotherapy for terminal cancer patients, Dr. Senay will present new clinical considerations, including recent data on current trends in abuse of legal and illegal drugs, as evidenced through local and national data. Dr. Senay will discuss phencyclidine, "T's and Blues," and new data on marijuana toxicity. A brief description of the fetal alcohol syndrome will be included.

**Family Therapy: 2:00 p.m.**

Lee Gladstone, M.D., director of the Alcoholism Treatment Program, Institute of Psychiatry, Northwestern Memorial Hospital. An assistant professor of psychiatry at Northwestern and former director of the Northwestern Memorial Psychiatric Day Hospital, Dr. Gladstone is the American Hospital Association Board of Trustees representative to the National Institute on Alcohol Abuse and Alcoholism. Family therapy in attacking psychological isolation of the substance abuser will be illustrated through role playing by Northwestern Alcoholism Treatment Program staff. In establishing alcohol and substance abuse as family problems, the presentation will approach the physician's role in providing support for family members, and examine the family dynamic.

**The Impaired Physician: 3:00 p.m.**

James W. West, M.D., chairman and founder of the ISMS Panel for the Impaired Physician, assistant professor of psychiatry, Rush-Presbyterian-St. Luke's Medical Center and director of alcoholism treatment services at Little Company of Mary Hospital in Chicago. Dr. West is medical director for the Central States Institute of Addictions and former chairman, Citizens Advisory Council on Alcoholism, IDMHDD. Programs to assist physicians impaired by dependence on alcohol and drugs, or physical and mental health problems which interfere with ability to practice medicine, will be discussed. In addition, Dr. West will review recent trends in alcoholism treatment, including in-house hospital committees for impaired physicians and establishment of alcoholism treatment services in the general hospital setting.

**Diagnosis and Treatment Overview: 4:00 p.m.**

Stanley E. Gitlow, M. D., clinical professor of medicine, Mount Sinai School of Medicine, New York City, and chairman of the Board for Professional Medical Conduct of New York State. A member of the AMA Council on Mental Health, Dr. Gitlow is also a consultant to the U.S. State Department. Dr. Gitlow will focus on the physician's role in the emergency room, hospital ward and private office settings in confronting alcohol and substance dependencies. He will emphasize the primary care physician's role in screening for dependency, providing patient education and family counseling. Finally, this presentation will provide a summary overview of diagnosis, triage and treatment of alcohol and substance abuse-related disorders.

This program is held in conjunction with the ISMS House of Delegates 1980 Annual Meeting at the Chicago Pick Congress Hotel. It is sponsored by the ISMS Committee on Alcoholism and Drug Dependence, with the support of a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism.

This seminar is cosponsored by the Illinois Council on Continuing Medical Education, which is accredited for continuing medical education by the AMA Committee on Accreditation of CME (CACME), and is valid for four hours of Category 1 credit acceptable for license-renewal in Illinois and for use toward the AMA 'Physician's Recognition Award.' This credit may also be acceptable toward the CME requirements of specialty societies and other organizations.

For further information, please contact the ISMS offices.

# MEDICAL-LEGAL MONTAGE

**Monday, April 14, 1980**

**7:30 p.m.**

## **Moderators:**

Donald Aaronson, M.D., J.D., *Chairman, ISMS Medical Legal Council*

Fred Grossman, J.D., *Chairman, Chicago Bar Association Medical Legal Committee*

### **—Confidentiality of health records**

Release authorization by patients  
Requests by attorneys  
Subpoenas

### **—Subpoenas**

Deposition  
Trial  
Records  
Fees

### **—Physician Experts**

Qualifications for Record Review  
At Trial  
Fees

### **—Disciplinary Processes**

Disabled physicians  
Peer Review—Obligations, rights,  
liabilities  
Reporting to regulatory agencies

### **—MD rights vis a vis hospital staff appointments**

New appointments  
Reappointments  
Curtailments on Privileges

### **—Liaison activities: medical and bar associations**

Physician and attorney complaint  
processes

### **—Panel discussions-questions and answers**

By the ISMS Medical Legal Council

*Special speakers from the bar and medical society will share their  
experience and expertise.*

## **CALLS WILL REACH YOU EASILY AT THE 1980 CONVENTION**

Doctor, please inform your staff that while you are attending the ISMS annual meeting, you may be reached through the ISMS Physician's Message Center from 10 a.m. to 5 p.m. Sunday and from 9 a.m. to 4:30 p.m. Monday through Wednesday at this number:

**312-427-3800**



# SBS PRESENTS

Student Business Session, Illinois State Medical Society

## HUMAN SEXUALITY

*The health care field has become increasingly more active in dealing with human sexuality. All physicians are now faced with assuming a progressive role in treatment and counseling and should be aware of the biosocial aspects of human sexuality.*

This program offers three (3) hours of CATEGORY 2 CME CREDIT for physicians.

## TREATMENT OF THE RAPE VICTIM

Anne Seiden, M.D., chairman, department of psychiatry,  
Cook County Hospital.

## HOMOSEXUALITY

Harry Rubin, Ph.D., Southern Illinois University School of Medicine

## SEXUAL DYSFUNCTION

Francois Alouf, M.D., associate professor of psychiatry and behavioral sciences; director, medical students' education and director, human sexuality program, Northwestern University Medical School.

ISMS/SBS Annual Meeting - following workshop

**SATURDAY, APRIL 12, 1980, 1-4 P.M.**  
**Pick Congress Hotel, 520 S. Michigan Avenue**  
**Chicago, Illinois**

Admission is free. The public is invited.

# Schedule of Associated Meetings

## *Resident Physicians Section*

**Saturday, April 12, 1980**

**8:00 a.m.-11:00 a.m.**

**1:00 p.m.- 5:00 p.m.**

*Seminar: Establishing Yourself in Private Practice*

Conducted by Robert J. Kramer, M.D.

For registration information, please contact ISMS headquarters  
RPS Annual Business Meeting and election of officers: 11:00 a.m.

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## *Student Business Section*

**Saturday, April 12, 1980**

**1:00 p.m.-4:00 p.m.**

*Seminar: Human Sexuality*

For registration information, please contact ISMS headquarters  
SBS Annual Business Meeting and election of officers: 4:00 p.m.

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## *Alcohol and Substance Abuse: Triage and Treatment*

**Saturday, April 12, 1980**

**1:00 p.m.-5:00 p.m.**

- Clinical Update
- Family Therapy
- The Impaired Physician
- Diagnostic and Treatment Considerations

Sponsored by the ISMS Committee on Alcoholism and Drug Dependence  
For further information, please contact ISMS headquarters



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*Illinois Medical Political Action Committee*  
*Annual Meeting*

**Sunday, April 13, 1980**

**11:30 a.m.**

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*ISMS Public Affairs Breakfast*

**Monday, April 14, 1980**

**7:30 a.m.**

Tickets available at ISMS registration desk

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*Fourth Annual Workshop for CME Accreditation Surveyors*

**Monday, April 14, 1980**

**Noon-1:30 p.m.**

- Update on CACME and Liaison Committee/CME
  - Problems encountered on site visits
  - Exchange of ideas and experiences
- 

*Illinois State Medical Inter-Insurance Exchange*  
*Annual Meeting of Members*

**Monday, April 14, 1980**

**1:00 p.m.**

- Election of Board of Governors
  - Ratification of auditors selected for coming year
  - New business
- 

*Medical-Legal Montage*

**Monday, April 14, 1980**

**7:30 p.m.**

- Liability and loss prevention
- The physician as expert witness
- Disciplinary processes
- Confidentiality of medical records

# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

March 1, 1980

### NOTIFICATION OF IMPAC ANNUAL MEETING

The 1980 annual meeting of the Illinois Medical Political Action Committee will be held on Sunday, April 13, 1980, immediately following the adjournment of the ISMS House of Delegates:

11:30 a.m.  
Great Hall  
Pick Congress Hotel  
Chicago, Illinois

All members of IMPAC are invited and encouraged to attend.


The 1980 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

#### Terms Expiring 1983

James Cavanaugh, Jr., M.D.	Winnetka
Herschel Browns, M.D.	Chicago
Robert D. Dooley, M.D.	Hinsdale
Robert T. Fox, M.D.	Glenview
Theodore Grevas, M.D.	Rock Island
Mrs. Jane Klaren	Libertyville
P. F. Mahon, M.D.	Springfield
George T. Mitchell, M.D.	Marshall
Mrs. Alan Taylor	Danville
George T. Wilkins, M.D.	Edwardsville

#### Term Expiring 1982

Cyril Wiggishoff, M.D.	Chicago
(to replace the late Dr. E. J. Jacobs of Arlington Heights)	



Herbert Sohn, M.D., Chairman

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.



# Resolutions

## 1980 Annual Meeting

### ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 10 and, according to provisions of the bylaws, are printed in *IMJ* by title and subject. Final deadline for resolutions was March 16. At this writing, it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

<i>Number:</i>	<i>Introduced by:</i>	<i>Subject</i>
80A-1	Charles J. Jannings, M.D. for the Wayne County Medical Society	Tuition Reimbursement
80A-2	Vernon H. Bartley, M.D. for the DuPage County Medical Society	Brain Death
80A-3	Morgan M. Meyer, M.D., for the DuPage County Medical Society	Resolutions Presented by the Resident Physicians Section and the Student Business Session
80A-4	Joseph R. O'Donnell, M.D., for the DuPage County Medical Society	Moratorium on Mandatory Continuing Medical Education

The following resolutions were submitted for consideration by the House of Delegates at its interim session in November, 1979. In accordance with the bylaws, the Committee on Rules and Order of Business recommended that these resolutions were not urgent enough to be considered at the interim session and, therefore, they were automatically carried over for consideration at the next annual meeting.

<i>Number:</i>	<i>Introduced by:</i>	<i>Subject</i>
79N-1	Samuel J. Schimel, M.D.	Recognition of Physicians' Assistants
79N-3	H. Frank Holman, M.D., for the St. Clair County Medical Society	Safeguarding the Human Rights of the Illinois Physician
79N-13	William H. Isham, M.D., for the Stephenson County Medical Society	Accomplishment of Goal by ICCME
79N-17	Finley Brown, Jr., M.D.	Incompetence
79N-19	Finley Brown, Jr., M.D.	Coding by State Agency
79N-23	Ronald M. Severino, M.D.	Funding for Professional Standards Review Organizations
79N-25	Finley Brown, Jr., M.D.	Medical Record Documentation
79N-30	H. Frank Holman, M.D., for the St. Clair County Medical Society	Need for a House of Delegates "Watchdog Committee"
79N-37	W. H. Brill, M.D., for the Kendall County Medical Society	Congressional Poll on a National Health Insurance Program

# CONVENTION '80

The 140th Annual Meeting  
*of the*  
Illinois State Medical Society  
*will be held at the*  
Pick Congress Hotel  
520 S. Michigan Avenue  
Chicago, Illinois  
April 13-16, 1980

- ISMS House of Delegates
  - Gala President's Party
  - Annual IMPAC Meeting
  - Public Affairs Breakfast

Further information about Convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Phone: (312) 782-1654.

## PLAN NOW TO ATTEND ....CONVENTION '80

April 13-16, 1980, Pick Congress, Chicago

ILLINOIS STATE MEDICAL SOCIETY APRIL 12-16, 1980	
ISMS ANNUAL MEETING	ISMSA ANNUAL MEETING
NAME _____	Date of Arrival _____
COMPANY NAME _____	
ADDRESS _____	Time of Arrival _____
PHONE _____	
CITY _____	Date of Departure _____
STATE _____ ZIP _____	
NAME OF 2ND OCCUPANT _____	Please advise arrival hour. Otherwise rooms held to 6 p.m. only. Request for late arrival will be held until 9 p.m.
<b>RATES:</b>	
SINGLES: \$45.00      DOUBLES OR TWINS: \$55.00	
MAIL TO: PICK CONGRESS HOTEL 520 S. Michigan Avenue Chicago, IL. 60605	
RESERVATIONS RECEIVED AFTER MARCH 27, 1980 WILL BE ACCEPTED ON "IF AVAILABLE BASIS."	
PLEASE CIRCLE DESIRED RATE IF RATE SELECTED IS NOT AVAILABLE NEXT HIGHEST RATE WILL BE ASSIGNED.	
PICK CONGRESS HOTEL CHICAGO	
Rooms Subject To 8.1% Illinois and City Room Tax	



# Illinois Society, American Association of Medical Assistants

## Annual Meeting Announced

The American Association of Medical Assistants, Illinois Society, will be participating in the Midwest Clinical Conference '80 at the Conrad Hilton Hotel.

The Illinois Society will have an all day educational workshop—"Youth of Today—Future of Tomorrow," Sunday, March 30, 1980, for all medical assistants, members and non-members. Topics to be covered are:

Growth and Development—George Moll, M.D., Ph.D.

School Years and Adolescence—Rosa Lee Moore, R.N.

Teenagers and Young Adults—Norma Nissen-son, Psychologist

Child Abuse and Parental Stress—Frances Stott, Ph.D.

For additional information regarding this workshop contact: Mrs. Mary F. Burton, Coordinator, 4747 King Drive, Chicago, Illinois 60615. Application has been filed with AAMA for awarding Continuing Education Units (CEU).

The McHenry Chapter is finalizing plans for the 24th Annual AAMA Illinois Society Convention, April 24-27, 1980, Arlington Park Hilton, Arlington Heights, Illinois.

Program plans are:

April 24, 1980

6:00 P.M. Registration  
Ribbon Cutting Ceremonies  
Welcome Party

April 25, 1980

10:00 A.M. House of Delegates  
1:00 P.M. Reference Committees  
3:15 P.M. House of Delegates Reconvenes  
7:30 P.M. President's Dinner

The Illinois Society will be honored (as in the past) to have the executive administrators and

presidents of the Illinois State Medical Society and the Chicago Medical Society address the House of Delegates.

April 26, 1980 Education Sessions

9:00 A.M.-

12:00 "Meeting the Emotional Needs of the Patient, Family, and Medical Assistant"—Dr. Robert L. Frank

12:30 P.M. Awards Luncheon

2:00 P.M.-

3:00 P.M. "Forensic Pathology"—Dr. Robert J. Stein

3:00 P.M.-

4:15 P.M. "The Legal Problems Affecting the Medical Assistant"—Attorney Almeta E. Cooper

7:30 P.M. Inaugural Banquet  
Installation of Officers

April 27, 1980

9:00 A.M. Farewell Breakfast

11:00 A.M. Executive and Council Meeting.

Application has been filed with AAMA for awarding Continuing Education Units for the educational programs.

Those interested in attending any part or all of this annual convention, contact Mrs. Helen Smith, 3612 West Anne Street, McHenry, Illinois 60050 for further information.

To the physicians—AAMA Illinois Society considers it a privilege to communicate to you through *your* Journal, and to continue our continuing education programs so we will be a vital part of the health care team.

For information regarding the Illinois Society, contact Cissy A. Elgy, CMA., President, 1413 Midland Manor, Joliet, Illinois 60436, or Luella V. Mitchell, Chairman, Public Relations, 7920 Eberhart Avenue, Chicago, IL 60619. ◀

## Case Report

# Ladd's Bands Causing Duodenal Obstruction In An Adult

BY SAM J. SUGAR, M.D., NORMAN E. LARSON, M.D., F.A.C.S., AND  
FRANK APANTAKU, M.D./EVANSTON

*Duodenal obstruction, secondary to incomplete rotation of the cecum with Ladd's bands, was found in a previously asymptomatic adult. Radiography was diagnostic and surgery was curative.*

Congenital abnormalities causing duodenal obstruction, although not uncommon in children, are very rare in adults. Boyd first described duodenal bands in 1845. The definitive description and surgical therapy were presented by Ladd<sup>1</sup> in 1932. In 1936, Krieg<sup>2</sup> reported the first successful surgery on an adult for obstructive symptoms from these so-called "Ladd's Bands." We report a case of duodenal obstruction due to Ladd's bands in a previously asymptomatic adult.

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FRANK APANTAKU, M.D., was senior surgical resident at the Northwestern University Medical Center at this writing.

NORMAN E. LARSON, M.D., F.A.C.S., is an attending physician in the department of general surgery at Evanston Hospital. Dr. Larson is an assistant professor of surgery affiliated with the Northwestern University Medical School and a fellow of the American College of Surgeons.

SAM J. SUGAR, M.D., is an internist affiliated with Evanston and Glenbrook Hospitals. Board certified by the American Board of Internal Medicine and director of medical education at Glenbrook Hospital, Dr. Sugar is a member of the ISMS Medical-Legal Council.

### Case Report

A 32-year-old female nurse's aid was admitted late in 1977, with a two month history of sudden onset of abnormal eructation, pain and postprandial nausea without vomiting. She denied recent weight loss but had always been slim. There was no history of anorexia, hematemesis or change in bowel habits. Occasionally, after meals, she would experience shortness of breath and "squeezing" left sided abdominal and chest pain for 30-60 minutes. Her health was otherwise excellent.

Physical examination revealed a thin female in no distress. There was moderate epigastric and left upper quadrant tenderness without rebound. Postprandially, an epigastric mass was palpable. Bowel sounds were normal and there was no visceromegaly.

Routine serologic, hematologic, chemical and urine screening tests were all normal. Stools for occult blood were negative.

Flexible fiberoptic gastroduodenoscopy revealed a normal gastric mucosa and a narrowed pylorus. Gastrointestinal radiography showed a normal esophagus and stomach (Figure 1). The proximal duodenum, however, was markedly dilated, with an incomplete obstruction at the junction of the second and third portions of the duodenum. Several linear compressions

consistent with bands were seen in this area. There was a small duodenal diverticulum. The small bowel was malrotated so that the proximal jejunum was on the patient's right. The remainder of the small bowel was normal.

Laparotomy was performed. The proximal duodenum was markedly dilated, measuring 10cm in diameter. There was no ligament of Treitz and the small bowel was in the right abdomen. There were dense bands attaching the cecum to the posterolateral part of the abdominal wall in the right upper quadrant, and obstructing the duodenum. A 1cm duodenal diverticulum was identified. The bands were lysed, allowing the incompletely rotated cecum to retract into the left upper quadrant, and freeing the obstructed duodenum. The duodenal diverticulum was left in place.

The patient had an uneventful postoperative course and has remained asymptomatic.

### Discussion

Duodenal obstruction due to congenital bands is rare in adults.<sup>3</sup> The most attractive hypothesis for the occurrence of these bands is that of incomplete rotation of the cecum during the fifth to the eleventh fetal week.<sup>4</sup> For reasons we cannot explain, our patient was apparently asymptomatic until her 32nd year.



**Figure 1**  
Gastrointestinal radiography showing a markedly dilated proximal duodenum with an incomplete obstruction at the junction of the second and third portions of the duodenum (arrow). Several linear compressions consistent with bands are seen.



The presence of the duodenal diverticulum might be related to prolonged increased intraduodenal pressure.

Gastroduodenoscopy was not helpful in this case, but gastrointestinal radiography was diagnostic. Surgical therapy was curative.

Although rare, Ladd's bands should be considered in the differential diagnosis of causes of duodenal obstruction distal to the duodenal bulb. ◀

#### References

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4. Boyden, E.A. *et al.*: "Anatomy and Embryology of Congenital Intrinsic Obstruction of the Duodenum," *Am. J. Surg.*, 114:190, 1967.

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# Membership Forum

*Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The Editors cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.*

*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

## On Evolution of Political Activists

When I entered into medicine, I did so with the innocence of a young idealist. I wanted to help. I wanted to heal. But I soon learned that the world is ruled by realities. I seldom attended the boring staff meetings. It was a waste of time for a busy physician. Until one day, I was rudely reminded that I was violating staff rules. What staff rules? "Why, the ones we passed last week." I found out that a small minority can sneak through vital rule changes when the audience is somnolent. There is no alternative. We must attend the staff meetings as a matter of survival. In time, I learned to live with the internal politics of the profession.

But this was just the beginning. When we entered into the Medicare era, the government developed an insatiable appetite to dominate the health professions and the industry. We were bombarded with rules, laws and regulations from Springfield and Washington. This massive overregulation was clearly not in the interest of the patient, the profession, the hospital or the community.

Private medicine is gradually becoming transformed into a semi-socialistic system not unlike public utilities. The judicial system allowed/ even promoted/ the financial exploitation of real and alleged short-

comings of this inexact biological science. It made our professional accountability almost Draconic, unique in history. Under such pressures the medical societies transformed into political interest groups. They spend larger and larger parts of their budget on political offense and defense. They develop specialists to deal with the bureaucrats, specialists to deal with the legislators. The art of healing clearly needs the support of the art of survival.

I long for a quiet niche where a pure healing art can be practiced but there is apparently less and less room for the Good Samaritans and the Albert Schweitzers. Viewing the controls and exploitations of this profession I must say with sadness that the time of the gentle healer is passed. We must develop the skills and toughness of the political activists.

James Scott, M.D.  
Streator

lawyer to a consultant who evaluated the case, and told them there was no basis for a suit. He told the physician that he would sue me anyway: "That it would not hurt my reputation and that he was sure he could get something from the insurance company."

Since the first consultant did not give her anything in her favor, she shopped around until she found somebody who told her things she wanted to hear. Then followed almost two years of the usual postponements and delays, schedules cancelled, endless hours of anger, frustration, disgust, etc. I was looking forward to fighting my case in court with no doubts I would win the case. The insurance company settled out of court. I was glad it was over, though I felt defeated.

I thought my rapport with this patient was good all along. The referring physician requested me to "see what I could do for this poor nice lady." When she came to my office with tears in her eyes because she did not have money, I offered to do the rhinoplasty for free and charged her 1/3 of my usual SMR fee, so her insurance covered everything.

I feel angry not only because I was sued but what I was sued for. All it takes is a special breed of patient (by no means rare) who saw an "opportunity," a two-bit lawyer who grabbed it faster than

## DOCTOR—BEWARE!

About three years ago I did a rhinoplasty-SMR on a nurse in the hospital under local anesthesia. Soon after, she sued me because she claims she felt pain during the procedure. She was sent by her



you can say contingency and a colleague out there somewhere, who, for reasons of his own made a few remarks that earned him the distinction of becoming her "expert" witness.

Could I have prevented this suit? I don't know. I don't think I would do anything different if I had to do it over. I always thought a patient needed a legitimate reason to sue. I was wrong.

Doctor,—beware!  
Jack M. Monasterio, M.D., F.A.C.S.  
Glen Ellyn

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## Cover Comment

To the Editor:

I was delighted to see the cover of the *Journal* (May, 1979). And frankly, I paid more attention to the *Journal* because of the interesting cover.

Perhaps you should invite physicians to submit slides or photographs for future use. As a matter of fact, I would be glad to volunteer a few flower photos myself.

Sincerely,  
Albert J. Miller, M.D.  
Chicago

*Editor's Comment: Dr. Miller's letter was among the incentives for discussion prompting the editorial on page 19 of our January issue (Volume 157: No. 1).*

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## Medical Inflation

Dear Sirs:

There is a general feeling across the nation that we should have cost containment, but I think the medical profession deserves a definition of what cost containment should be. Are we addressing physician cost, hospital cost, regulatory cost, etc?

It has been presented that the cost of medicine has increased between 1960 to 1979 from \$27 billion to \$192 billion. This "increased cost of medicine" is due to:

**A. Monetary Inflation**—Monetary inflation, over the last two years alone, has been running between 9% and 13% per year. Therefore, a minimum of 25% medical cost increases have involved monetary inflation alone.

**B. Regulatory Inflation**—New York State has demonstrated that 25% of hospital costs are due to satisfying government regulations.

**C. Administration Inflation**—In 1960 there was usually one administrative position in each institution, and now there are many institutions with as many as seventeen administrative posts.

**D. Malpractice Inflation**—Malpractice insurance has gone from \$200 to close to \$7,000 for individual practitioners and for others from \$500 to as much as \$36,000. However, this is not even the greatest cost of malpractice insurance. It is not even the juries awarding greater amounts of money. The extra cost is the extra testing that individuals must do to "cover themselves." Before, emergency room work could be easily handled with \$10 to \$20 worth of tests, and now as much as \$85 worth of testing is done to "cover for malpractice."

**E. Medical Advancement Inflation**—No one discusses that the medical product in 1979 is a totally different product than it was in 1960. We did not have the sophisticated invasive angiographic procedures, CAT scans, gastroenterologic workups, cardiovascular workups, arrhythmia analysis, computerized EKG's, the explosive workup and management of infectious disease problems, or the explosion of information in allergy, immunology, rheumatology, etc. How many endoscopies at \$300

each are being performed now, that, in 1960, were \$10 proctoscopies? Of course, the accuracy of diagnosis is definitely increased, and from 1967 to 1977 man's life has lengthened by three years in one decade. This is only because of the advancements of medicine.

**F. Government Underpayment and Inflated Patient Visits**—The "paying patients" must pay for any "cost overrun" that Medicare and Medicaid doesn't pick up. This inflation is never alluded to. In 1960, the average individual might have gone to a physician once a year, and some people only went every two to three years. Now the average individual goes to the doctor four times a year. This marked increase in physician visits means that we have "inflated" the number of physician visits.

**G. Division of Labor Inflation**—This last aspect of inflation is the total new product again, because of the division of labor. There used to be family practitioners, surgeons, and a few obstetricians, internists, and pediatricians. Now, there is a division of labor in which the family practitioner takes care of one small portion. If the patient has a serious infection, he is seen by an infectious disease specialist. If he has a gastroenterologic problem, he is not only seen by a gastroenterologist, infectious disease man, and a surgeon, but if the patient has any cardiovascular complication, a cardiologist is called in. Subspecialist after subspecialist leads to an increased division of labor and an inflation of total medical cost. To be sure, the product is better and the outcome is improved by this division of labor.

Someone in the medical profession must address cost containment, but no one spells out the aspects of medical inflation to which I have alluded. Therefore, I certainly bring this to your attention. ◀

Sincerely,  
Robert H. Harner, M.D., F.A.C.C.  
Rockford

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** Wanted—American-trained family physician to join established family physician in active practice. Guaranteed salary and excellent benefits. Eventual partnership. Robert N. Arrol, M.D., 126 South Locust, Arcola 61910 or 217-268-4444 or 217-268-4404. (4)

**ATKINSON:** A modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond-Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles to Peoria (UI). All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235 (309-936-7566). (7)

**AURORA:** Population 80,000. Opening in 40 man multi-specialty group—located 45 miles from downtown Chicago. Complete office and ancillary services available. Starting salary and benefits with stockholder status, two years. Contact Leonard E. Snyder, 1870 W. Galena Blvd., Aurora, 60506. (312) 859-6700. (3)

**CHICAGO AREA SUBURBS:** Western Cook, DuPage Counties, including Oak Brook, Downers Grove, Wheaton, Lombard, LaGrange, Palos Hills. Opening in new and established multi-specialty medical groups. Complete office facilities with nearby hospital affiliations. Various practice and financial arrangement available. General Practice, Internal Medicine, Family Practice, Obstetrics & Gynecology, Otolaryngology, and Orthopedic Surgery. CONTACT: Jim Gott, Administrator, Suite 205, 6800 S. Main Street, Downers Grove, 60515, 312-852-9400. (12)

**DAVENPORT, IA:** Ten man group with two OB-GYN's seeks another OB-GYN partner. Attractive offer now with promising future. Send C.V. We will call. Gordon Rock, M.D., The Davenport Clinic, 1820 West Third Street, Davenport, Iowa 52802. (7)

**DEKALB:** Northern Illinois University, a state university of approximately 22,000 enrollment, needs a sports medicine/emergency room physician to serve as university team and trauma room physician. Qualifications: Illinois license to practice medicine and surgery and pertinent experience in sports medicine and trauma care. Salary competitive; good fringe benefits. Ten or twelve months per year. To start July 1 or August 1, 1980. Contact: Loren W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, 60115. Northern Illinois University is an Equal Opportunity/Affirmative Action employer. (7)

**EL PASO:** Family practitioner for rewarding primary care and family physician. Fully equipped office in excellent location. Primarily farming community in North Central Illinois. Fifteen miles from hospitals in Normal-

Bloomington with cultural advantages of two universities—Illinois Wesleyan, and Illinois State University. Ten miles from Eureka Hospital and 35 miles to Peoria with U of Ill Medical School and Bradley University. Financing available. A warm, personal community that would welcome a needed physician. CONTACT: Kearney Clinic, 3 Grant Street, El Paso 61738 (309-527-5752). (7)

**FREEPORT:** Urologist, Ob-Gyn, and General Surgeon, Board Certified or Eligible, to join multi-specialty group in community of 35,000 in Northern Illinois. Salary negotiable first year, then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, Illinois 61032. (815-235-6131) (7)

**FAIRBURY:** Primary Care and Family Practice Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (12)

**FREEPORT:** Orthopedic Surgeon—Pediatrician—Otolaryngologist—Needed to join 20 physician, multi-specialty clinic. New facilities, fully equipped, adjacent to hospital. Attractive financial arrangement with many fringe benefits. No investment. Contact J. S. Schoenberger, Business Manager, Freeport Clinic, S. C., 1036 West Stephenson Street, Freeport, 61032, AC 815/235-5111. (12)

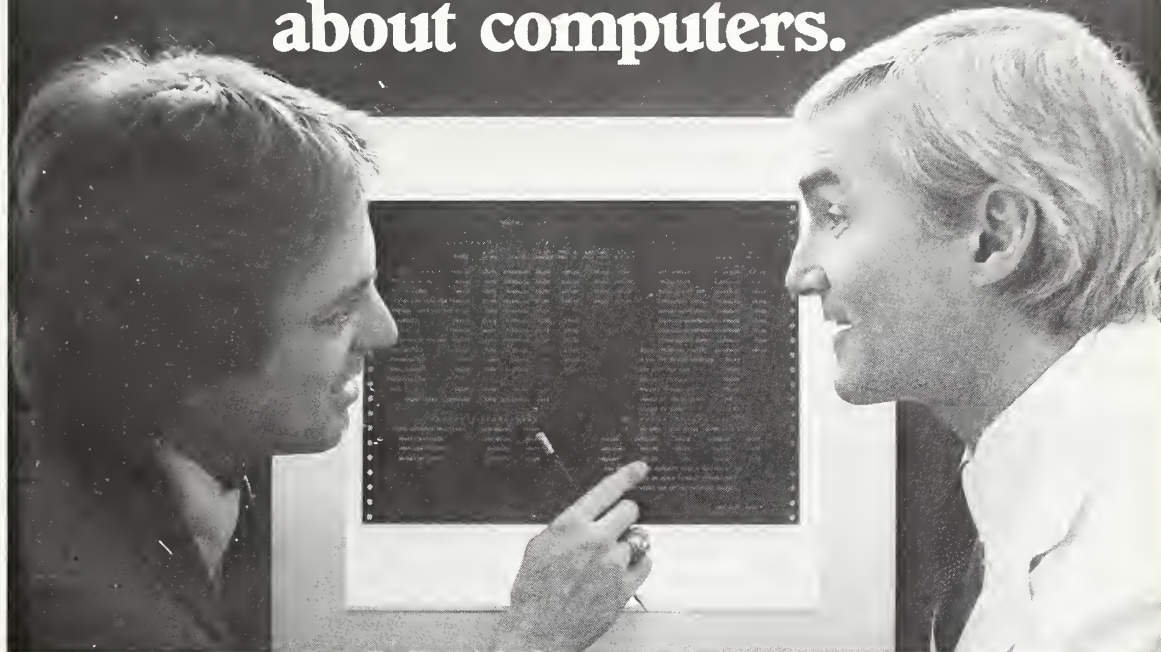
**GALESBURG:** Opening for full time emergency physician in modern trauma center hospital. 12,000 annual visits. Excellent specialty backup. Good salary and flexible schedule. Very nice community, population 36,000. Contact: Fares N. Aris, M.D., St. Mary's Hospital, 3333 N. Seminary St., Galesburg, 61401. (309) 344-2919. (3)

**GENESE:** Family Practice/Pediatrician/Internist/Orthopedic acutely needed. Ultra modern hospital. Walk in office, complete facilities. Population 7,000, trade area 29,000. 150 miles from Chicago, Interstate 80. 25 miles from Quad-Cities. Nine physicians at present. Contact: Mrs. A. W. Wellstein, 9 Maplewood, Geneseo, 61254 Ph. AC 309-944-2530. (3)

**GENOA:** Population 3500 (surrounding area 15,000). Excellent professional and cultural opportunity for physician seeking independent family practice. Pleasant family community. Located between Chicago, DeKalb, and Rockford. 15 miles from Northern Illinois University. Contact: Irving M. Bush, M.D., 1 Chapman Road, Burlington, 60109. Phone 312-683-2066 or 312-683-2081. (4)



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# Abstracts of Board Actions

(Continued from page 139)

## MEDICAID

The Board deferred action on a member's request that ISMS sue IDPA over policies concerning audits and patient confidentiality . . . and denied a request that ISMS pay legal expenses involved in contesting his possible termination from Medicaid. The Board noted that the Society is not in a position to assume legal expenses of individual members, and emphasized that last May the House of Delegates directed ISMS to rely upon negotiations to resolve problems with IDPA. Those negotiations recently have met with some success, and relations with IDPA are improving.

The Board also declined the member's request to provide a team of physicians to peer review his records prior to his reaudit by IDPA, questioning the value of such review which is not binding upon the Department. Instead, the Board voted to urge IDPA to make Department-sanctioned peer review available to all physicians undergoing audit and to offer ISMS assistance in recruiting physicians for the task.

## PEER REVIEW HANDBOOK

The Board approved a handbook—governing the conduct of peer review activities—designed to guide district and county review committees. The handbook is based upon bylaws provisions adopted last May by the ISMS House of Delegates. Copies will be distributed to county societies.

## REVISIONS IN POLICY MANUAL

In accordance with House of Delegates' action, the Board approved the following policy statement on "Ethics" for inclusion in the Policy Manual:

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.

Also in accordance with House action, the Board approved revisions in policy statements on the following subjects for inclusion in the Policy Manual: public health departments, medical schools, governmental health insurance programs, voluntary health insurance plans, smoking, and medical liability insurance premiums.

The Board will introduce a resolution at the upcoming Annual Meeting urging the House of Delegates to rescind a policy which binds ISMS and its component societies to decisions of the AMA House.

At its meeting last November, the ISMS House of Delegates directed the Board of Trustees to develop a policy statement delineating what it considered to be proper activities for local and state health departments. The Board will ask the House to adopt the following statement:

ISMS encourages public health liaison committees of component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community by considering: (1) The socio-economic characteristics of the population to be served; (2) The availability of private medical services; (3) The gaps in medical and health services that should be filled by public health activities; and (4) Restricting public health programs to those individuals and families demonstrating economic need.

## ALLIED HEALTH PROFESSIONALS

The Board adopted the following guidelines concerning professional relationships between physicians and allied health personnel:

### Supervisory & Collaborative Relationships

- A supervisory relationship exists between a physician and an allied health professional when the physician is responsible for management of a patient's care as long as the prescribed treatment continues under the physician's supervision.



- A collaborative relationship exists when the physician and an allied health professional provide complementary functions relating to the patient's care or treatment plan. The physician must be in a position to provide periodic re-evaluation of the patient's condition through personal examination, so that a revision or continuation of the patient's medical treatment, as clinically indicated, may be instituted.

#### **Fees of Allied Health Professionals Employed by Physicians**

- Prior to medical treatment, a diagnosis and treatment plan must be made by a physician.
- Fees charged for services rendered by an allied health professional under the direction or supervision of a physician should accurately reflect the various types and levels of care provided.
- In a team of practitioners, or a multi-disciplinary team, reimbursement should be based upon a mutually agreed upon and set fee or salary, open to renegotiation when changes occur.
- A physician employing an allied health professional may bill for the service of such person including a fee for supervision, diagnosis or medical management.

The Illinois Hospital Licensing Board (IHLB) will be notified of the ISMS position that "diagnosis, therapeutic prescription and hospital admissions are only within the scope of fully-licensed physicians." The IHLB is considering amendments to the Hospital Licensing Act regulations, which, if enacted, would allow non-physician management of the mentally-ill.

#### **LEGISLATION**

During the 1980 General Assembly session, ISMS will: (1) Oppose a bill (HB 625) that would create a Health Expense Limitation Plan allowing the director of IDPH to pay—on behalf of eligible persons—health care expenses exceeding specified limits; and (2) Support a proposal (HB 1517) that would ban smoking in certain public places, including hospitals. In related action, the Board voted to develop legislation that would allow unmarried minors—who are parents—to receive medical care without the consent of their parents.

#### **HEALTH DATA**

The Board endorsed a planned survey—developed by the Illinois Cooperative Health Data System—designed to ascertain physician manpower in Illinois. The Illinois Department of Registration & Education will include the survey with license renewal applications mailed to physicians in late April. A cover letter—signed by the ISMS president and ICHDS chairman—urging physicians to complete the form will be included in the mailing.

ISMS will urge the Illinois Cooperative Health Data System to explore with the Illinois Department of Mental Health & Developmental Disabilities arrangements whereby ICHDS would assume responsibility for gathering statistical data on involuntary psychiatric hospital admissions and discharges. The Board also authorized ICHDS to utilize an ISMS-developed questionnaire to obtain the data. Current IDMHDD data is incomplete, ignoring more than 20 private facilities. A major problem could develop if the data is used by HSAs and federal and state agencies in budgeting funds and resources for mental health care.

The Society will pursue development of a unique physician identifier number which could be used for the Medicaid program and other purposes. The need for the unique number arose when AMA recently forced IDPA to discontinue use of the ME number as an "identifier" on Medicaid invoices. The ISMS House of Delegates is opposed to use of the Social Security number as an "identifier."

#### **HOUSE, BOARD MEETING DATES**

The following dates and locations were selected for Board of Trustees and House of Delegates meetings:

##### *House of Delegates (Interim Sessions)*

Nov. 15-16, 1980	Peoria Hilton, Peoria
Nov. 14-15, 1981	Springfield

### *Board of Trustees*

June 28-29, 1980

Sept. 13-14, 1980

Nov. 14-16, 1980

Nov. 13-15, 1981

Marriott O'Hare, Chicago (tentative)

Palmer House, Chicago

Peoria Hilton, Peoria

Springfield

## **ALCOHOLISM**

Acting to expand the Society's ongoing alcoholism education program—supported by a grant from the IDMHDD Division of Alcoholism—the Board voted to:

- Urge Illinois medical schools to expand training in the diagnosis of alcohol and drug abuse in medical school curricula.
- Encourage county societies to: (1) Utilize the ISMS Alcoholism Education Speakers Bureau; (2) Notify ISMS of local physicians expert in treatment of alcoholism; and (3) Form committees to treat impaired physicians.
- Devote the Society's exhibit at the 1980 Illinois State Fair to providing information on substance abuse, fetal alcohol syndrome and hypertension detection.
- Implement a public education campaign pointing out the relationship between societal pressures and substance abuse.

## **SPECIAL PROGRAMS**

Acting on requests concerning special programs, the Board voted to:

- Authorize development of an educational effort directed at the ISMS membership on the topic of physician-sponsored health care systems. The extent of the educational effort will be conducted within existing budgetary limits.
- Co-sponsor a conference this spring on the fetal alcohol syndrome in conjunction with the March of Dimes, IDMHDD, Illinois Nurses Association and Lutheran General Hospital, Park Ridge.
- Authorize a half-day workshop during the ISMS annual meeting on the topics of substance abuse and the fetal alcohol syndrome.
- Co-sponsor an Illinois Department of Public Health program, February 14, in Peoria, designed to "sensitize" county health department nurses to the jail environment. ISMS also will co-sponsor a similar program in March.
- Approve plans for a half-day seminar on medical-legal topics during the ISMS annual meeting. Topics will include due process, disciplinary procedures, lien laws, and expert witnesses.
- Approve scheduling an issue-oriented legislative workshop, May 21, at the Springfield Hilton Hotel. Speakers will include the General Assembly leadership, directors of key state departments and, possibly, Governor Thompson.
- Set the Public Affairs Breakfast during the ISMS annual meeting for Monday, April 14, at 7:30 a.m. Featured speaker will be announced in the near future.
- Endorse an Illinois Continuity of Care Coordinators' Workshop—on discharge planning and utilization review—scheduled May 6-7, in Champaign. The program is co-sponsored by Blue Cross/Blue Shield and Illinois Hospital Association.

## **ILLINOIS RAPE STUDY**

At the request of Rep. Aaron Jaffe, chairman of the Illinois Rape Study Committee, ISMS recently convened a meeting to consider development and implementation of programs—in residency medical schools, residency programs and hospitals—to train health personnel in treatment of sexual assault victims. The session was attended by representatives of hospital associations, specialty societies, victim advocate groups as well as medical and nursing educators. As a result of that meeting, the Board voted to:

- Submit a resolution calling upon AMA to ascertain which national specialty boards include board test questions on appropriate treatment of rape victims . . . and to urge those that currently do not have such questions to include them in future tests.



- Assist the Chicago Hospital Council in revising its manual dealing with treatment of rape victims.
- Urge the Illinois Department of Children and Family Services to strictly enforce the Child Abuse Act in cases of rape and sexual abuse.
- Publish articles in the *Illinois Medical Journal* concerning treatment of rape victims.
- Assist in publicizing upcoming IDPH hospital staff seminars on treatment of rape victims.
- Urge IDPH to include in its fiscal 1981 budget sufficient funding for a staff member who would: (1) Monitor implementation of the Rape Victims Emergency Treatment Act; (2) Coordinate in-service training for hospital personnel; and (3) Promote distribution of Vitullo Evidence Collection Kits and train personnel in its use.

## SPORTS MEDICINE

ISMS will support efforts of the Governor's Council on Health and Fitness to develop mechanisms that would require high school athletic coaches to document: (1) Cardio-pulmonary resuscitation training; and (2) Continuing education in prevention and management of athletic injuries.

## IDPA DRUG MANUAL

The following drugs were approved for inclusion in the IDPA Drug Manual: Perdiem, Iberet-Folic 500, Loniten, Tri-Cone Capsules, Vicon Forte, Corgard, Surmontin, Stadol and Pediazole. ISMS will urge IDPA to remove the drug Selacryn—in all its forms—from the Drug Manual. Smith, Klein & French recently recalled the drug following reports that clinical use of Selacryn caused "significant hepatic injury."

## NEW IDMHDD DIRECTOR

ISMS will offer to assist Gov. Thompson in seeking a successor to Dr. Robert deVito, who announced he will resign on June 30 as director of the Illinois Department of Mental Health & Developmental Disabilities. The Board agreed that the IDMHDD director should be a psychiatrist, a requirement outlined in current statute. Drs. Arthur Traugott, Champaign, and Leroy Levitt, Chicago, were named Society representatives on a special four-member ISMS-Illinois Psychiatric Society committee that will be formed to seek a qualified candidate for the post.

## APPOINTMENTS/NOMINATIONS

The Board approved the following appointments to ISMS committees:

- *Committee to Study Membership Recruitment Activities and Costs*—Drs. Lawrence Hirsch, Chicago; Alfred Clementi, Arlington Heights; Alfred Kiessel, Decatur; P. John Seward, Rockford; and Robert Hartman, Jacksonville.
- *Committee on Health Planning*—Dr. Joseph O'Donnell, Glen Ellyn.
- *Committee on Laboratory Services*—Dr. John Mason, Hinsdale.
- *Committee on Physician Recruitment-Rural*—Drs. Lloyd Koritz, Rochelle, and William Van Bergen, Springfield.
- *Loss Prevention Education Committee*—Drs. Alfred Clementi, Arlington Heights; Warren Tuttle, Harrisburg; Philip Boren, Carmi; Robert Hartman, Jacksonville; Walter Whisler, Chicago; and Richard Wilbur, Lake Forest.
- *Illinois Medical Journal Editorial Board* (two-year terms): Dr. Eugene Rogers, Chicago. Reappointed were: Drs. Ediz Ezdinli, Kenilworth, Carl Neuhoﬀ, Peoria; and Donald Van Fossan, Springfield. Current terms of Board members were extended by four months to make them coincide with those of other ISMS councils and committees.

At the 1979 Interim Session, the House of Delegates indicated it would support changes in Illinois statute allowing appointment of a non-physician to head IDPH provided a Medical Policy Board is created and given full authority to determine medical policy. The Board will consist of two public health MDs, two medical school MDs and three practicing MDs. IDPH Acting Director William Kempiners has agreed to create such a board as an advisory body pending pas-

sage of the necessary legislation. ISMS will submit nominees for appointment to the advisory body which eventually will become the Policy Board.

Also nominated for appointment to state posts were:

- *Illinois Health Facilities Planning Board*—Dr. Alex Goldstein, Harrisburg
- *IDPH Alcoholism Treatment Advisory Council*—Dr. Lee Gladstone, Chicago
- *IDPH Medical Advisory Committee on EPSDT Program & Child Health Examinations*—Drs. Richard Dukes, Urbana; and Edward DuVivier, Alton
- *IDPH Board of Public Health Advisors*—Drs. Shirley Roy, Chicago, and G. W. Giebelhausen, Peoria

IDPH requested ISMS assistance in evaluating the professional services offered at an Illinois hospital. While the Society informed IDPH it would not participate in the evaluation, it provided the Department with the names of six physicians who agreed to be "deputized" as IDPH agents for the project. They are: Drs. Nathaniel Berlin, Janet Wolter and Robert Schmitz, all of Chicago; Thomas Hoeltgen, Oak Lawn; and Stephen Reid and Ed Scanlon, both of Evanston.

The Board agreed to support the candidacies of: Dr. John Ring, Mundelein, for re-election to AMA Council on Medical Service . . . and Dr. Jack Gibbs, Canton, for election to AMA Council on Medical Education.

Acting as corporation members of ICCME, the ISMS Executive Committee elected the following as ISMS representatives to the ICCME Board of Directors: Drs. E. Chester Bone, Jacksonville; Alfred Clementi, Arlington Heights; Kenneth Hurst, Naperville; Alfred Kiessel, Decatur; William Lees, Lincolnwood; Donald Pochyly, River Forest; Roger Wujek, Litchfield; and Dean Bordeaux and Fred White, both of Peoria. Upon nomination of their respective medical schools, the following were elected to the ICCME Board as representatives of those schools: Drs. Michael Dykes, Northwestern Univ. School of Medicine; Chase Kimball, Pritzker School of Medicine, Univ. of Chicago; Harold Paul, Rush Medical College . . . and Ben Blivaiss, Ph.D., Chicago Medical School; Martin Kernis, Ph.D., Univ. of Illinois College of Medicine; Charles Osborne, Ed.D., Southern Illinois Univ. School of Medicine; and Ward Perrin, D.O., Chicago College of Osteopathic Medicine. A representative of Loyola Univ. Stritch School of Medicine will be elected to the ICCME Board at a later date. ◀

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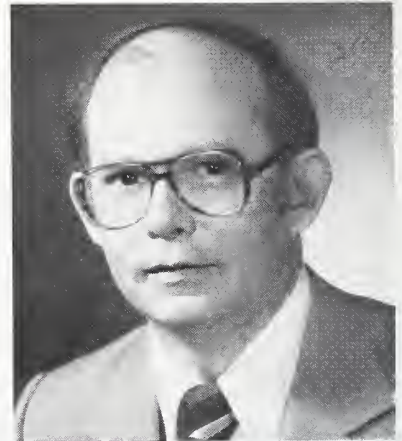
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# President's Page

*"When we remember that we are all mad, the mysteries disappear and life stands explained."*

Mark Twain



## The Wonderland of Government

I recently was in Washington where I heard an assortment of bureaucrats explain how government will "help" our ailing economy by devising yet another layer of regulations. Apparently the principles of a free economic environment now are "inoperative," having been replaced by something I find difficult to describe. Perhaps all allegorical scenario is appropriate.

Imagine a milking parlor full of prime producing cows. Production will continue at maximum efficiency as long as the cows are supplied with the things they need, such as water, grain and the tender loving care of the concerned farmer. But what would happen if: . . .

- The grain is sporadically stopped and water is rationed?
- Government issues a fiat directing one cow to stop producing so that the market price of milk rises?
- A cost containment program is implemented that permits milking only once a day?
- A consumer-dominated national milk production planning agency is created to make decisions concerning expansion of milking parlors?
- A local rendering plant representative—who is standing by waiting for spilled milk—is permitted to slaughter the miscreant?

The answer is obvious: Milk production would drop and total chaos would engulf the milk industry. By changing definitions and the vocabulary, the allegory today can be applied to nearly every field, including medicine.

Without expeditious use of courage and restraint, the allegory will shift from the humorous to the deadly serious. It has the potential to become a continuing metaphor where the practice of medicine will be regulated by Alice-In-Wonderland logic. ◀

A handwritten signature in cursive script, reading "P. John Seward, M.D.".

P. John Seward, M.D., President



# Doctor's News

**PHYSICIANS IN THE NEWS**—**Joseph R. Eraci, M.D.**, Elmhurst, has been named director of the Loyola University Medical Center's Ambulatory Care Center. A clinical assistant professor in internal medicine, Dr. Eraci will maintain his current responsibilities as director of primary care at Loyola . . . **Earl Suckow, M.D.**, Mount Prospect, chief pathologist at Holy Family Hospital, has been named chairman of the board of directors for the North Suburban Blood Center and North Suburban Association for Health Resources.

St. Therese Hospital in Waukegan has announced newly elected medical staff officers. They are: **Frank Juras, M.D.**, Fox Lake, chief of staff, **H. James Solomon, M.D.**, Zion, president-elect and **James Baehr, M.D.**, Waukegan, secretary.

**ILLINOIS CONGRESSMAN RECEIVES RECOGNITION**—The U.S. Office of Personnel Management recently honored Illinois Congressman Edward J. Derwinski by implementing the Udall/Derwinski award for federal agencies, state governments and individuals who bring about notable reforms in civil service systems. The Office of Personnel Management granted the first award since the Civil Service Reform Act of 1978 to the National Aeronautics and Space Administration. The award was named for Representatives Derwinski and Udall in recognition of their work toward civil service reforms.

**PSRO SEMINAR ANNOUNCED**—The American College of Utilization Review Physicians, Illinois Chapter, will sponsor a one-day meeting, April 27, 1980, at the Drake Hotel in Oakbrook, Illinois. "Future of PSRO in the 80's," will offer insights to a practice-oriented approach to quality assurance, utilization review and cost containment issues. Category 1 continuing medical education credit will be available to participants. Further information may be obtained by writing Eugene V. Handelman, M.D., chapter president, ACURP National Office, 1108 N. Second St., Harrisburg, PA 17102.

**NUTRITION SYMPOSIUM ANNOUNCED**—ISMS will join the Chicago Nutrition Association and Chicago Section-Institute of Food Technologists in sponsoring a one-day seminar, April 30, 1980, entitled "Use and Abuse of Food Substances—Technological and Health Implications," at the Chicago Pick Congress Hotel. Five hours Category 1 continuing medical education credit will be available to physicians attending the seminar, which will focus on food additives and the most recent food technology. Presentations will include: "Hyperkinesia—A Food Related Problem," "Use of Added Substances in Food," and "Hypertension, Sodium and Salt." An advance registration fee of \$30 includes luncheon. Further information may be obtained by writing: CNA-IFT-ISMS Symposium, c/o Lucy Morrow, Box 502, Glenview, IL 60025; or telephone contact to Therese Mondeika, American Medical Association, (312) 751-6524.

**FIRST ANNUAL DRUG ABUSE CONFERENCE ANNOUNCED**—The Illinois Dangerous Drugs Commission will sponsor the "Illinois Institute on Drug Abuse—1980," May 28-30 at Milliken University in Decatur. The Institute is designed for drug abuse workers and persons interested in related issues. Administrative, medical, and prevention approaches are among those included in the presentations. Further information may be obtained through the Illinois Dangerous Drugs Commission, 300 N. State St., Suite 1500, Chicago, IL 60610; (312) 822-9860.

**FAS CONFERENCE ANNOUNCED**—For the second year, ISMS has joined the Illinois Nurses' Association and Lutheran General Hospital in co-sponsoring a workshop coordinated by the Governor's Citizens Advisory Council on Alcoholism and the Governor's Planning Council on Developmental Disabilities.

The one-day workshop on the Fetal Alcohol Syndrome (FAS) will be held June 25, 1980, at the UI Chicago Circle Center, 750 S. Halsted. The seminar will focus on new research in FAS, genetic factors and the effect of male parents' drinking patterns. Cynthia Herman, Ph.D., a child psychologist affiliated with the University of Washington Medical School, Seattle, will discuss environmental aspects contributing to the syndrome. Hour for hour Category 1 Continuing Medical Education credit will be available to participants. Further information may be obtained by contacting Emma C. Redmond, Division of Alcoholism, IDMHDD, (312) 793-2907.

**SEXUAL ASSAULT TREATMENT SEMINARS**—The Illinois Department of Public Health will sponsor a series of one-day seminars, 9:00 a.m. to 3:00 p.m., for hospital emergency department personnel treating victims of sexual assault. Seminars will familiarize participants with the Vitullo Evidence Collection Kit for Sexual Assault Examination, available to hospitals at no cost from the Illinois Law Enforcement Commission (ILEC). The kit contains materials to facilitate evidence collection and provide corroborative evidence in prosecution of assailants. In addition, it offers information to the victim about treatment, and necessary follow-up testing for venereal disease or pregnancy. Seminars will also focus on emotional trauma, law enforcement and legal aspects of sexual assault treatment.

Seminars are sponsored by IDPH, The Illinois Department of Law Enforcement, Citizens Committee for Victim Assistance and ILEC. Dates and locations of seminars are as follows: March 31—St. Joseph's Hospital, Elgin; April 2—Decatur Memorial Hospital; April 8—St. Joseph's Hospital, Joliet; April 10—Zeller Zone Center, Peoria; April 22—McHenry Hospital; April 25—Burnham City Hospital, Champaign; April 30—Moline Public Hospital and May 6—St. Anthony Hospital, Rockford.

**SIXTH ANNUAL CONFERENCE ON AGING ANNOUNCED**—A series of three two-day sessions, March 28-29, April 11-12 and April 25-26, at Sangamon State University, Springfield, will focus on the aging process. Entitled, respectively, "Ethical Decision: Who Decides for the Elderly," "Terminal Care: Meaning and Implications," and "Creativity and Aging," the workshops will begin with Friday sessions, 11:00 a.m.-9:00 p.m. and conclude with Saturday sessions, 9:00 a.m.-1:00 p.m. The second session, on terminal care, offers 10 hours of category 1 Continuing Medical Education credit for physicians. A registration fee for each independent session is \$35; advance registration for all three is \$87. Registration includes materials, coffee, dinner and continental breakfast. Further information may be obtained by writing: Gerontology Program, Cox House, Sangamon State University, Springfield IL 62708. Telephone: 1-800-252-8533 (toll free Illinois only.)

**INTRAVENOUS THERAPY CONVENTION ANNOUNCED**—The National Intravenous Therapy Association, Inc., will hold their eighth national convention May 4-8 at the Marriott Hotel in Atlanta, Georgia. Inquiries should be directed to N.I.T.A., Inc., 93 Concord Ave., Suite 4, Belmont, MA 02178.



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# REPORT

## FOR *Illinois Physicians*

### AMA Official's Views On NHI

*Following are excerpts from the presentation of Robert B. Hunter, M.D., president-elect of the American Medical Association, at the recent Symposium on National Health Insurance sponsored by the Chicago-based Blue Cross and Blue Shield Plan.*

There used to be a rather good newspaper in this country, the *National Observer*. It went defunct two and one-half years ago, but just before its demise, in a front-page article, one of our prominent political figures said, "Our medical accomplishments are unsurpassed . . . both in the research of our scientists and the clinical competence of our doctors . . . This growth of medical knowledge is unparalleled in the history of mankind, and we take well-deserved pride in these achievements."

You will be interested to know that the author of that was Edward M. Kennedy. Now, Senator Kennedy is convinced a mandatory, government-run program of national health insurance would enable all Americans to get the kind of treatment he praises. My own conviction is that it would enable all Americans to get less of that kind of care.

**Before explaining that, I want you to look at the present health care delivery system.**

It is a highly developed system that includes some 350,000 physicians, some 5,000,000 other personnel, and more than 7,000 hospitals. So, it is a system in which we physicians see a staggering average of 3 million patients a day.

It is a system in which no fewer than nine in ten individuals already have private or "public" health coverage.

It is a versatile and varied system, with fresh modes of health care delivery to meet

medical and socioeconomic needs as they arise.

I readily grant that our system has gaps that need to be filled, defects that need to be rectified.

But these gaps are being narrowed. We have a National Health Care Service Corps, with which the American Medical Association is cooperating. We have voluntary areawide planning, which the AMA has encouraged, and an increase in the number of medical graduates entering primary care training.

**The opportunity for containment of expenses is limited by the fact that most of them are inescapable. What can we do about a 13.3 percentage general inflationary rate?**

And yet, remarkable strides against these rising costs have been made through what is known as the Voluntary Effort, a coalition that includes the AMA, the American Hospital Association, Federation of American Hospitals, Blue Cross and Blue Shield, labor, local government and consumers.

Remedial measures are being taken in the health care system, and largely in the private sector.

Now, isn't it far better to make needed correction in this most proficient health care system in the world, than it is to rebuild it in accordance with government ambitions and blueprints?

A mandatory, federalized program of national health insurance could allot such commanding positions to regulation, to economic abstraction, and to geopolitics, that health care itself would be thrust into a rear seat.

The administration's phased-in NHI program would ultimately make the federal government as domineering as Senator Kennedy's bill.

## AMA Official's (cont'd)

The Kennedy bill would create a national health board to regulate and control the entire health care system, exercising vast powers over health budgets, insurers and premium rates.

Health care spending under the Kennedy bill would be controlled by annual budgets established by the national board at both the national and state levels. Future increases would be limited to the increase in the Gross National Product, totally ignoring technological improvements and advancements that research might bring to us.

Hence, there would be budget limitations that could, and would, impose the rationing of care in this country.

Yet, while restricting the cost and provision of care, the Kennedy program would be very costly, because of the mandatory comprehensiveness of its coverage, as well as its administrative apparatus.

Now, I should note at this point that the provisions in the Kennedy NHI program with employer-employee contributions cannot be considered as anything but a tax, and as all taxes in our country have gone, those, too, would go up.

The only consolation in the Kennedy bill or the administration's phase-by-phase approach is that neither is likely to be enacted in the foreseeable future.

**Senator Russell B. Long's bill, providing largely for catastrophic coverage, is considered the one most likely to succeed in the halls of Congress.**

Yet there appears to be little likelihood that any NHI legislation will get through the present Congress.

We have the demand that the federal government economize in a recessionary period, when its runaway budgets of past years have been attacked as a major cause of inflation.

Second, the Senate's surprise decision to adhere to a tight new domestic budget, requiring painful cuts by Senate committees and precluding much that is new.

And third, the confusion resulting from the welter of NHI proposals.

For many years, the AMA has grappled with the challenge of how to move ahead on health insurance, but in a manner that avoids the pitfalls.

From 1970 to 1978, in each of those years, we introduced our own NHI legislation—legislation calling for both basic and catastrophic coverage.

Last year, our House of Delegates decided that instead of tying ourselves to such bills in an uncertain economic and political climate, we should simply work for certain principles and act as circumstances warranted.

And those four principles are:

1) Minimum standards of adequate benefits for health insurance policies, with deductibles and coinsurance.

2) A system of uniform federal, state and local government benefits for those who cannot provide for their own medical care.

3) A nationwide private insurance program to make catastrophic coverage available, with government assistance on reinsurance if necessary. Again, there would be deductibles and coinsurance to keep down costs and abuse.

4) Administration of this program at the state level with national standardization establishing guidelines only.

**We are working assiduously for the system of privately-focused health insurance because this is the system through which high quality care can best be offered to all of the people.**

However, if a government-run national health insurance program is to be avoided, it is important to fill the gaps in insurance coverage and thereby boost the people's confidence in their ability to pay for their care.

Knowing the high number of people already covered by health insurance, we also know the gaps that exist among some elements of the population, and believe in closing them.

We are firmly behind a broader distribution of catastrophic coverage.

Whatever challenges of any kind are in order, in the delivery and financing of health services, they must always be handled with care, lest quality be damaged or shattered.

There is an inescapable triangle of quality, access and cost, and no one side of the triangle can either be enhanced or diminished without affecting the other two, nor can any two be affected without the diminishing of the third.

So, as we move in the area of national health insurance, let "health" be the foremost of those three words.





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# Crippled Children's Clinics

Forty clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 11 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- May 1 Lake County Cardiac—Victory Memorial Hospital
- May 1 Pittsfield—Illini Community Hospital
- May 1 Sterling—Community General Hospital
- May 1 Effingham—St. Anthony Memorial Hospital
- May 2 Division Cardiac—U. of I. at the Medical Center
- May 6 Alton—Alton Memorial Hospital
- May 6 Park Ridge Cardiac (a.m.)—Lutheran General Hospital
- May 6 Park Ridge General (p.m.)—Lutheran General Hospital
- May 6 Wheaton General—Marianjoy Rehab. Hosp.
- May 7 Hinsdale—Hinsdale Sanitarium
- May 7 Mt. Vernon—Good Samaritan Hospital
- May 8 Aurora Cardiac—Mercy Center for Health Care Services
- May 8 Springfield General—St. John's Hospital
- May 8 Macomb—Medical Bldg. of McDonough District Hospital
- May 12 Chicago Heights Cardiac—St. James Hospital
- May 12 Peoria Cardiac—St. Francis Hospital
- May 13 East St. Louis—Community Hospital
- May 13 Peoria General—St. Francis Hospital
- May 14 Chicago Heights General—St. James Hospital
- May 14 Joliet—St. Joseph's Hospital
- May 14 Rock Island CP—Foundation for Crippled Children and Adults
- May 14 Champaign-Urbana—McKinley Hospital
- May 15 Rockford—Rockford Memorial Hospital
- May 15 Anna—Union County Hospital
- May 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- May 16 Kankakee Cardiac—St. Mary's Hospital
- May 19 Chicago Heights Cardiac—St. James Hospital
- May 19 Peoria Cardiac—St. Francis Hospital
- May 20 Belleville—St. Elizabeth's Hospital
- May 20 Rock Island Area General—Moline Public Hospital
- May 20 Decatur—Decatur Memorial Hospital
- May 20 Maywood—Loyola Medical Center
- May 21 Evergreen Park—Little Co. of Mary Hospital
- May 22 Centralia—St. Mary's Hospital
- May 27 Peoria General—St. Francis Hospital
- May 27 Maywood General (half-day ortho only)—Loyola Medical Center
- May 28 Springfield Ped-Neuro—St. John's Hospital
- May 28 Elgin General—Sherman Hospital
- May 28 Chicago Heights General—St. James Hospital
- May 29 Elmhurst Cardiac—Memorial Hospital of DuPage County

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

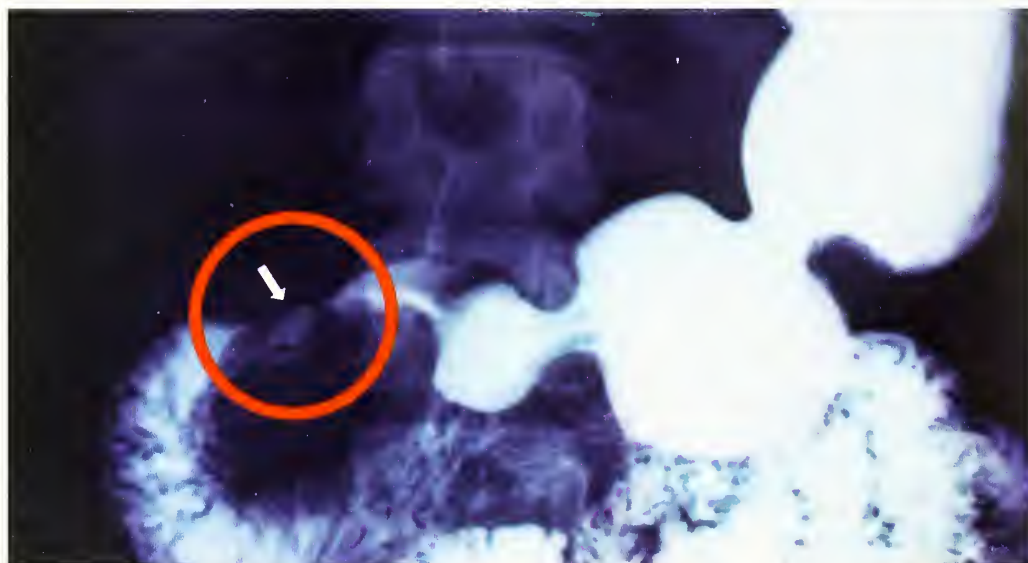


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# The stress-secretion relationship in duodenal ulcer\*



The pituitary gland plays a key role in the neurohormonal response to emotional stress, leading to an increase in gastric secretion.<sup>2</sup>



The duodenal ulcer reflects the erosion of a vulnerable mucosa by acid-pepsin secretion.<sup>2</sup>

The best available evidence<sup>1,2</sup> suggests that chronic anxiety stimulates acid-pepsin secretion. Also, the development of an ulcer crater in predisposed individuals, or the aggravation of ulcer symptoms, is often associated with a stressful event or situation.<sup>1</sup> Thus, anxiety seems to play an important role in the course and prognosis of the disease.<sup>1</sup>

To obtain more comprehensive relief, many duodenal ulcer patients need more than specific, acid-inhibiting medication. They also need reduc-

tion of accompanying anxiety and emotional tension.

**References:** 1. Isenberg J, Richardson CT, Fordtran JS. Pathogenesis of peptic ulcer, chap. 46, in *Gastrointestinal Disease*, ed. 2, edited by Sleisenger

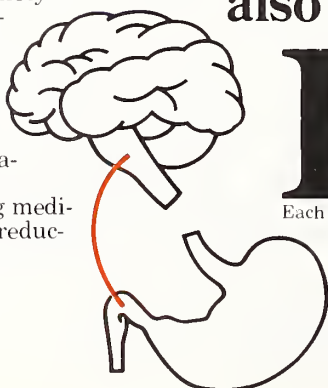
MH, Fordtran JS. Philadelphia, WB Saunders Company, 1978, vol. 1, pp. 800-801. 2. Sun DCH. Etiology and pathology of peptic ulcer, chap. 27, in *Gastroenterology*, ed. 3, edited by Bockus HL, et al, Philadelphia, WB Saunders Company, 1974, pp. 579-595.

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\*Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on preceding page.

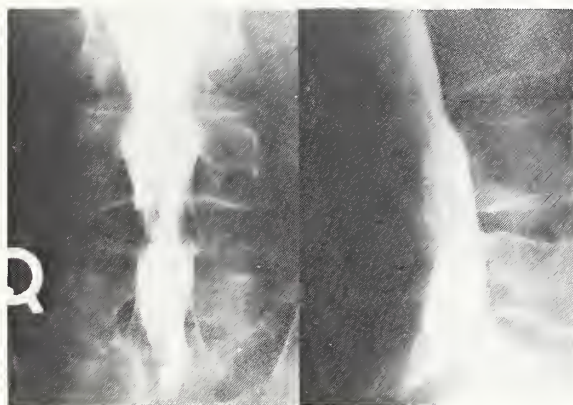


# The Viewbox

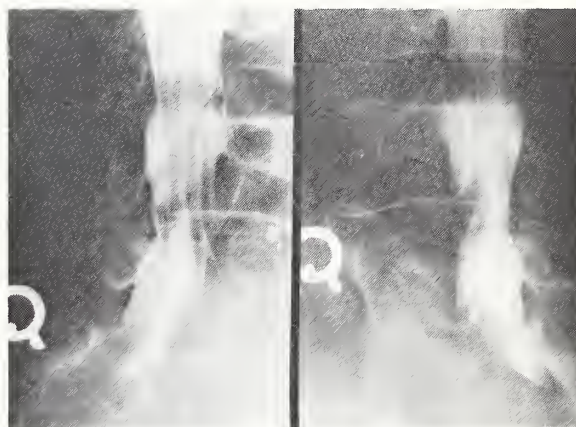
Contributing Editor Leon Love, M.D., chairman, Department of Radiology, Loyola University Stritch School of Medicine

*This month's viewbox was submitted by Sergio Heredia, M.D., Enrique Palacios, M.D. and Michael Fine, M.D., from the Neuroradiology section, Dept. of Radiology, Loyola University Medical Center, Maywood.*

*This 67-year-old male was admitted with a four month history of right thigh and leg pains.*



**Figure 1A** **Figure 1B**  
Lumbar myelogram. (A) PA and (B) Lateral views



**Figure 2A** **Figure 2B**  
Lumbar myelogram.  
(A) Left oblique and (B) Right oblique views

## What's your diagnosis?

1. Neurofibromatosis
2. Herniated Disk
3. Epidural Lipomatosis
4. Lymphoma
5. Arachnoiditis
6. Seeding Chordoma

*(Continued on page 235)*



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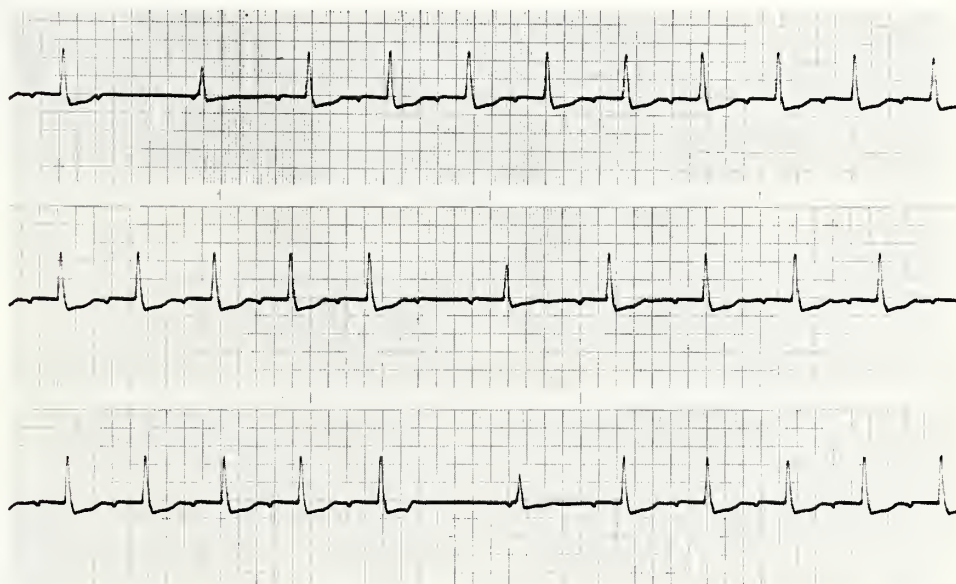
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# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnor, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This is a 75-year-old man who presented for evaluation of intermittent light-headedness. He had initially attributed this to his advanced age and became concerned only when these episodes became more frequent. He was in good health otherwise and had no previous medical history of note. Physical examination showed a healthy elderly man in no distress. The only abnormal finding was an irregular cardiac rhythm. The ECG rhythm strip shown here was recorded.*



## Questions:

### 1. The ECG rhythm strip shows:

- A. An ectopic atrial rhythm at a rate of 72 beats per minute.
- B. Type II atrioventricular block (Mobitz).
- C. Non-conducted premature atrial beats.
- D. Junctional escape beats with slight aberrant intraventricular conduction and an escape interval of 1520msec.

E. All of the above.

### 2. Treatment for this patient would include:

- A. Permanent demand pacemaker.
- B. Digoxin 0.25 mg. per day.
- C. Procainamide 250 mg. four times a day.
- D. Quinidine 300 mg. four times a day.
- E. Intravenous Lidocaine 100 mg. bolus followed by an infusion of 2 mg. per minute.

(Continued on page 246)

# V-Cillin K<sup>®</sup>

penicillin V potassium

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**Warnings:** Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

**Precautions:** Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting,

gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

[102175]

**\*Equivalent to penicillin V.**

*Additional information available to the profession on request.*



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# I M J

Illinois Medical Journal

Vol. 157, No. 4, April, 1980

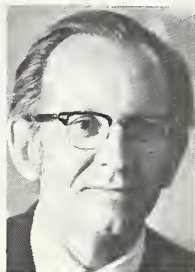
## From Chaos To Landmarks

### IDPH Looks At Diabetes In Illinois

*The purposes of the diabetes project of the Illinois Department of Public Health are threefold. First, the project seeks to assess the needs of diabetics in Illinois in epidemiological terms of person, time, and place. Second, these needs are evaluated in relation to existing services. Finally, the project seeks to develop broad-based citizen and professional support for bridging gaps and remedying deficiencies in present resources. Our baseline data indicate higher hospitalization rates for diabetics. Data further suggest that population-based rates of complication and hospitalization will provide a reliable measure of improvement in control. Patient education for responsible self-care is expected to result in better long-term control, lower complication rates, fewer average annual hospital days, and fewer needless deaths.*

BY BURTON C. DYSON, M.D., GARY L. GURIAN, M.A. AND BYRON J. FRANCIS, M.D., M.P.H., ILLINOIS DEPARTMENT OF PUBLIC HEALTH/SPRINGFIELD

In 1921, with the discovery of insulin, diabetes became a controllable disease. In the 1940's, vascular complications were recognized as a major



BURTON C. DYSON, M.D., is a board certified anatomic and clinical pathologist and chief, Chronic Disease Section, Division of Disease Control, Illinois Department of Public Health. Former associate clinical director of the department of family practice of Cook County Hospital, Dr. Dyson is a volunteer consultant for health affairs to the Institute of Cultural Affairs, based in Chicago.

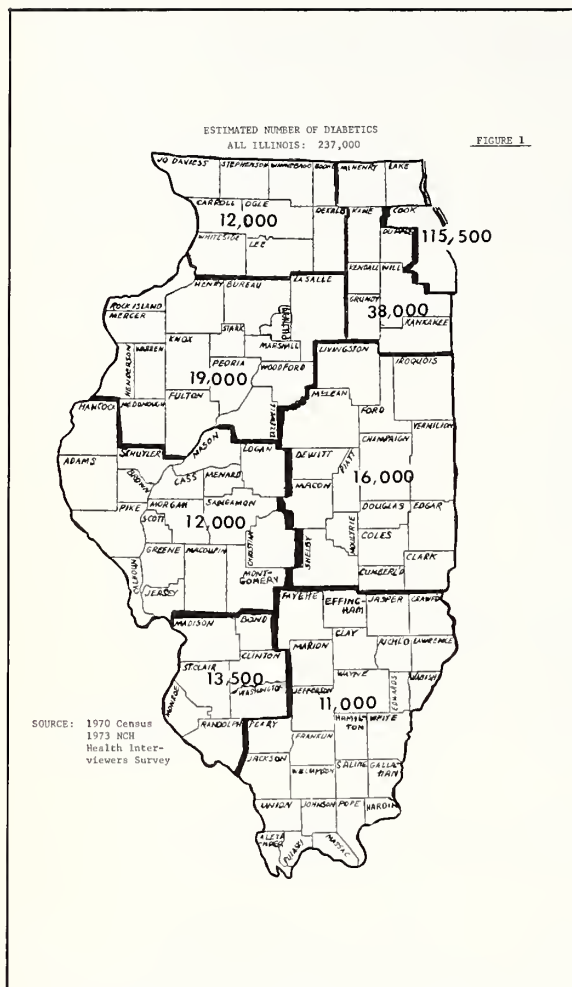
GARY L. GURIAN, M.A., is coordinator of the Diabetes Program for the Illinois Department of Public Health. He is also former field epidemiologist and public health representative to the Venereal Disease Control Program, IDPH.

BYRON JOHN FRANCIS, M.D., is immediate past acting director of the Illinois Department of Public Health. Board certified by the American Board of Preventive Medicine in public health, Dr. Francis currently serves as chief for the IDPH division of disease control. He has also served as adjunct associate professor in epidemiology for the UI School of Public Health in Chicago.

cause of morbidity and mortality. Thirty years later, work by Pirart<sup>1</sup> and others finally established that microangiopathy is significantly reduced by long-term good control. Laser photocoagulation reduces blindness for diabetic retinopathy,<sup>2</sup> the leading medical cause of blindness. We know now that insulin is not a cure. We also know that patient education for responsible self care can reduce complications.<sup>3</sup>

Individual desire for health can be harnessed to create a community desire for health, where essential services are assured for all citizens.<sup>4</sup> (Figure 1) We in the health field can have great influence in shaping public policy. The Illinois Department of Public Health has added chronic disease services to its long standing commitments in basic sanitation, disease surveillance, and control of communicable disease.

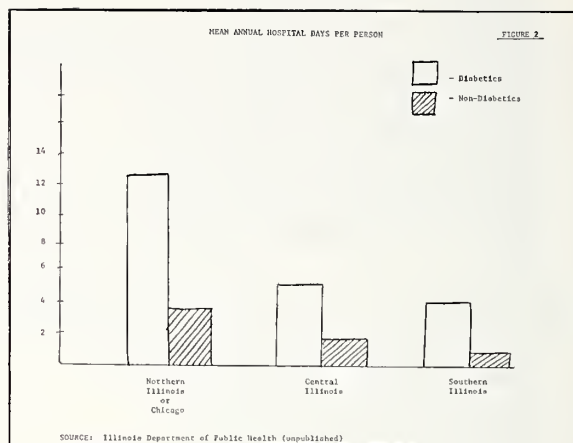
As in acute disease, we look beyond the struggle of individual persons and families suffering from a major life-shortening illness ("patients"). We measure progress by rates and proportions of the estimated quarter million persons in Illinois who are diabetic.



**FIGURE 1**  
Estimated Number of Diabetics  
All Illinois: 237,000  
SOURCE: 1970 Census,  
1973 NCHS Health Interviewers Survey

Excellent programs in Grady Memorial Hospital,<sup>3</sup> Atlanta, have established beyond doubt the cost effective benefits of patient education in reducing diabetic morbidity. Work of Miller and Goldstein<sup>5</sup> in Los Angeles and Runyon<sup>6</sup> in Memphis has established the cost-effectiveness of nurse-directed, physician-supervised teams of primary care in decreasing both the need for hospitalization and morbidity. We in Illinois are only now beginning to apply this knowledge.

We began the first inventory of resources in Illinois for services needed by diabetics and chose these categories: patient education, social services, medical services, professional education, surveillance of morbidity, planning, finance, manage-



**FIGURE 2**  
Mean Annual Hospital Days Per Person  
SOURCE: Illinois Department of Public Health  
(unpublished)

ment and public information. We characterized each of these services as to content, availability, and utilization. We noted in which categories information is now available, is available in the future, or is not attainable.

This inventory quickly confirmed our first intuition that secondary and tertiary level services generally are of good quality, widely available and properly utilized. The adequacy of primary level services remains to be evaluated.

Contemplating the health needs of a quarter million chronically ill persons in Illinois can be overwhelming. Physicians faced with the initial chaos of an epidemic have had to decide upon relatively simple and available measures, such as a fever chart and a clean blanket for every patient. What could we use as a "fever chart" for a quarter million diabetics? How would we locate areas where the problem is out of control? We chose mortality rates which are available by age, sex, and county. We selected, also, the morbidity rates of annual hospital days, admissions for ketoacidosis, and rates of lower extremity amputation. (Figure 2)

When we studied unpublished hospital morbidity tabulations assembled by the Illinois Hospital Association, one finding immediately caught our attention: the five-fold increase in average annual hospital days for all causes when diabetics were compared with nondiabetics. In Grady Hospital, this increase has been almost eliminated by persistent patient education. (Figure 3) We shall also study admission rates for ketoacidosis and rates of lower extremity amputation. We have ar-

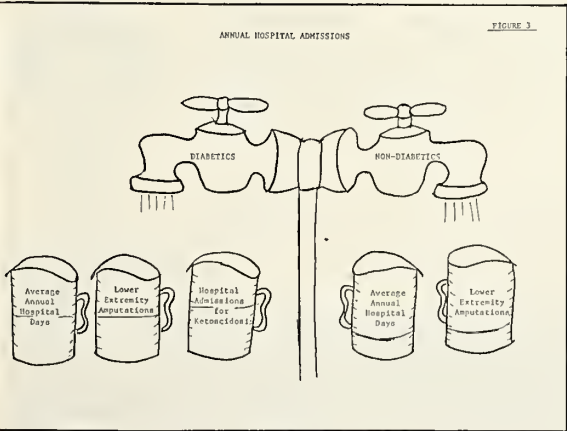


ranged with the Illinois Cooperative Health Data Systems, Inc., to receive quarterly tabulations of these morbidity rates for each county and each Chicago community area beginning later this year. Another newly recognized concern is diabetes in pregnancy. Amankwah's<sup>7</sup> study of 1184 pregnant women in a private central Illinois practice showed a high 4.5% perinatal mortality, and 13.6% incidence of major birth defects in the 6.0% of the patients with maternal diabetes.

As the initial equivalent of a clean blanket for every patient in our epidemic situation, we chose a patient education program meeting six criteria: there is a program coordinator; instructors receive structured training; there is a written teaching plan; curriculum components include disease orientation, insulin injection instruction, urine testing, diet instruction, foot care, and emergency care instruction; a structured teaching setting exists such as classroom, small group, individual; and finally there is post course measurement of the students' learning.

In examining programs to educate diabetic persons in 66 Illinois agencies, including 48 hospitals, we discovered only 17 which met all 6 of our criteria. Eight programs met none of the criteria. Fifty-two programs (79%) had a specified meeting place; 41 (62%) had a written teaching plan; 35 (53%) had post program testing procedures.

Interdisciplinary professional education is needed to make available the best in current knowledge and services throughout all portions of the state. We began by offering to a nurse and a dietician from selected hospitals in the state a five-day update in professional education. We expect that these professional educator teams in each of



their hospitals will be able to improve the total education of the diabetics hospitalized. We intend to measure the effectiveness of the improved patient education upon hospital readmission rates for ketoacidosis and for lower extremity amputation.

Will such professional and patient education reduce morbidity? Intuitively, we think it will, as the literature suggests; *but in Illinois*, we will not know until patient morbidity experience after such education has been tabulated through 1980. There is considerable professional uneasiness when this question is discussed seriously.

We in Illinois are not alone in exploring unknown territories in chronic disease control. In Rhode Island and in Pittsburgh a registry of all diabetics is under development. Michigan is considering a similar registry. Other states and univer-

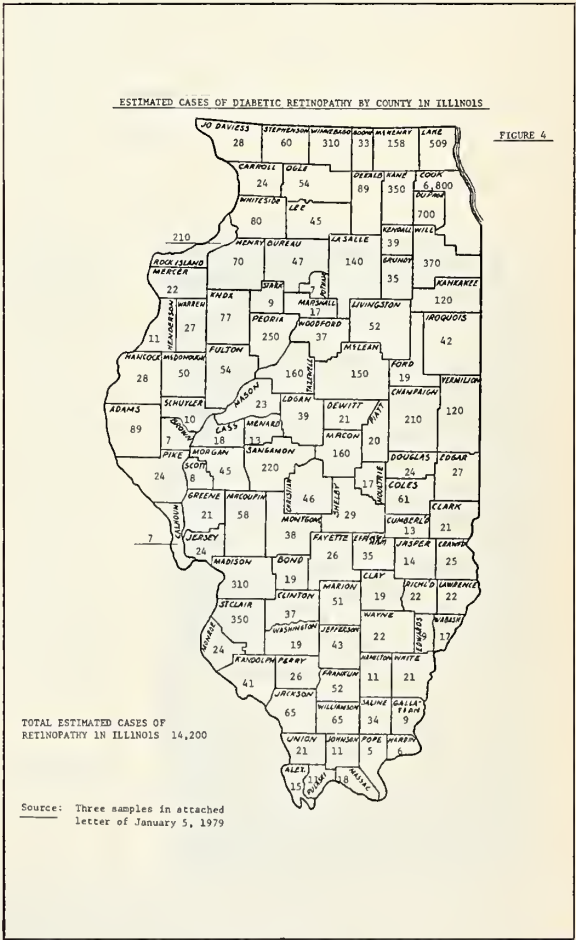


FIGURE 4  
Estimated Cases of Diabetic Retinopathy by County in Illinois: 14,200  
SOURCE: Illinois Department of Public Health (unpublished)

sities and the Rand Corporation are developing improved tools to measure and direct patient education.

What of the future? (Figure 4) Diabetic retinopathy is the leading medical cause of blindness. Twenty-five years after onset of disease 85% of diabetics suffer this retinopathy. In one series, 17% of patients found to have retinopathy suffered blindness in the succeeding two years. A parallel group of patients treated with photocoagulation incurred half this incidence of blindness. The map shows where in the state diabetic persons with retinopathy are believed to live. We hope to develop a way to measure case finding rates in each of these areas and to locate those parts of the state and of the population where diabetics are not being referred for laser therapy. This may become a new "fever chart" of services in diabetes in Illinois. With our professional and patient education programs and new outcome measures we shall further develop a capability for locating parts of the state and of the population where morbidity and mortality appear out of control. Special attention can be directed to these areas.

Looking to the future, we hope that methods

and knowledge developed in this Diabetes Project will be useful in reducing needless complications of other chronic diseases, enhancing the quality of life, and vigorous participation by increasing numbers of older Americans whose work and wisdom will be essential to the common good. ◀

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# Successful Hyperalimentation in a Community Hospital

BY LAWRENCE HOLLANDER, M.D., F.A.C.S., JEFFREY J. GLASS, M.D., AND  
SIDNEY BLACK, M.D., F.A.C.S./HIGHLAND PARK

*Since 1969 when Dudrick,<sup>1</sup> et al., popularized intravenous hyperalimentation, this mode of therapy has revolutionized treatment of in-hospital "starvation" states associated with inflammatory bowel disease,<sup>2</sup> postoperative surgical complication,<sup>3</sup> chemotherapy, or any disease state associated with protein calorie starvation. This study reviews the indications, complications, results and technique of intravenous hyperalimentation at a community hospital. At this hospital of some 330 beds, patients are treated outside an intensive care unit environment.*

The day before intravenous hyperalimentation is to be initiated, the patient is bathed with Betadine skin cleanser several times. On the following morning, he is premedicated and another scrub is given by an attending physician. The patient is again prepped, draped, and the superior vena cava is catheterized percutaneously through the infraclavicular subclavian route with local anaesthesia. This procedure employs the eight-inch large bore Bardik intracatheter, which is then sutured to the skin. A post-insertion chest X-ray is always obtained to check catheter posi-

tion and to verify that the lung is fully expanded without a pneumothorax.

The insertion site is dressed with Betadine ointment and covered with gauze and silk tape. It is bathed every 48 hours with Betadine skin cleanser, Betadine solution ointment, tincture of Benzoin, and then redressed. The area is observed for signs of local infection and signs or symptoms of jugular or axillary thrombophlebitis.

On the day of insertion, the patient receives a 10% dextrose solution through the subclavian route. The next morning intravenous hyperalimentation is begun, delivered by a volumetric infusion pump. The patients are begun at 2000 kilocalories per day and slowly advanced to 5000 kilocalories per day as tolerated. The patients are initially followed by daily weights, electrolytes, BUN, and FBS. CBC, SMA-12, serum calcium, magnesium and prothrombin times are followed less frequently. The intravenous tubing is changed daily under sterile conditions.

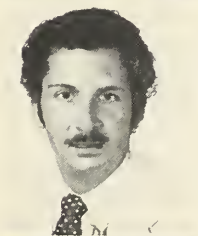
Most recent changes added to the regimen include twice weekly infusion of intralipid through a peripheral IV and discontinuation of the final millipor filter because of leakage when it becomes clogged.

Standard hyperalimentation solutions are used and electrolytes and vitamins are added as needed. No medications are added on the floor or through the IV line. The solutions are mixed under the laminar-flow hood in the hospital pharmacy.

When hyperalimentation is discontinued, the patient receives a 10% dextrose solution for another 24 hours until his augmented insulin levels decrease. This prevents any sudden episodes of hypoglycemia. The catheter tip is always cultured upon withdrawal. At this point the patient is generally eating a solid diet. Electrolytes, minerals and vitamins are added in the pharmacy as needed. Insulin is administered to keep the fasting blood sugar below 200 mg.



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JEFFREY J. GLASS, M.D., is director of the division of gastroenterology at the Chicago Medical School, where he also serves as a clinical assistant professor of medicine. Dr. Glass is a former fellow in gastroenterology at the University of Chicago Hospitals and Clinics.



SIDNEY BLACK, M.D., is a diplomate of the American Board of Surgery and fellow of the American College of Surgeons affiliated with Highland Park and Skokie Valley Community hospitals. A clinical associate professor in the department of surgery for the University of Illinois College of Medicine, Dr. Black is vice president of the Chicago Surgical Society and president-elect of the Warren H. Cole Surgical Society.

## Results

In our series, 24 patients have been hyperalimented over the past year. Fourteen of the patients were women and 10 were men. Ages ranged from 16 to 69 years. Fourteen patients were treated for inflammatory bowel disease, either idiopathic ulcerative colitis or granulomatous colitis and four were treated for gastric outlet dysfunction secondary to either preoperative or postoperative ulcer disease. Six were treated with concomitant malignancies in order to increase tolerance to effective dose levels of their chemotherapeutic medications.

All patients were beyond the pediatric age group and none were treated permanently,<sup>4</sup> for burns,<sup>5</sup> or for renal failure.<sup>6</sup> Of the 24 patients treated, the length of time of catheter insertion averaged approximately 3.2 weeks (ranging from four days to six weeks.)

Weight gain could be controlled by adjusting caloric intake, and weight gain averaged from one pound to 10 pounds per week by varying the calories from 2000 to 5000 calories per day. (The patient who averaged 10 pounds per week was also being treated with intravenous corticosteroids and some weight gain was undoubtedly based upon water retention.)

## Complications

One clinical complication noted was a pneumothorax in a 68-year-old white male with chronic obstructive lung disease and gastric outlet dysfunction. The patient pulled out the right-sided subclavian line, and on inserting another catheter from the patient's left side a pneumothorax developed. This necessitated insertion of a chest tube for approximately 48 hours. Another complication (which was not clinically significant) was one positive culture which yielded coagulase negative staphylococcus on a catheter that had been in place approximately four weeks although the patient was not septic. No catheter was removed because of sepsis or thrombophlebitis.

## Discussion

Many papers have appeared on the clinical success of intravenous hyperalimentation. This paper reports the success at a community hospital. Most previous reports discuss a hyperalimentation team.<sup>7</sup> At our institution the physicians involved in the procedure select the patients, assess nutritional status, insert the catheter, care for the catheter site, prescribe appropriate formulations of intravenous fluid and direct patient monitoring. Nurses throughout our institution have been instructed in intravenous hyperalimentation technique and patient monitoring as well as use of the infusion equipment. We do not find it necessary to use an intensive care unit

environment. This allows patient mobility, television, radio, and other amenities forbidden in the intensive care unit. Gratifying results were seen in reversing exacerbations of inflammatory bowel disease, weight gain, reversal of toxic megacolon, increasing chemotherapy tolerance, opening postoperative anastomoses that were slow to open, and preparing patients for surgery from a debilitated state.

Numerous complications have been previously reported that basically divide into three categories; mechanical, metabolic, and septic. We treated one case of pneumothorax necessitating insertion of a chest tube. In this series there were no episodes of tension pneumothorax, hemothorax, hydrothorax, mediastinal blood or fluid, nerve injury, cardiac arrhythmia, venous hemorrhage, catheter embolism, myocardial perforation or pulmonary embolism, as have been reported elsewhere.<sup>8</sup> There was no morbidity directly related to hyperalimentation.

Metabolic complications did not develop. There were no hypo or hypercalcemia, hyponatremia,<sup>9</sup> hypo or hypermagnesemia, hypo or hyperkalemia, hypophosphatemia, hyperchloremic acidosis or non-ketotic hyperosmolar hyperglycemia. Recently, routine back rubs with soy bean oil have been replaced with intralipid given intravenously twice weekly. This appears to have stopped the exfoliative dermatitis associated with essential fatty acid deficiency. We anticipate determining if intralipid can prevent reversible elevations of liver enzymes that are seen with long term hyperalimentation. It is possible at this time to administer zinc as well as copper in the hyperalimentation solutions.

We feel that septic complications have been kept to a minimum. Goldmann *et. al.*, reported a 7% incidence of catheter-induced septicemia.<sup>10</sup> In our series, there was coagulase negative staph on one catheter on routine culture at the end of therapy. There was no evidence of bacterial or fungal catheter septicemia. No catheter was removed because of a febrile episode. According to protocol, we are notified if the temperature of the patient reaches 102 degrees (temperatures are taken Q.I.D.) or if any unusual change in glucose tolerance is noted (which frequently heralds the onset of sepsis). We feel that the septic complications have remained absent because one person cares for the central venous catheter rather than multiple nurses scattered throughout the hospital changing the dressings. In this situation, a uniform technique is utilized and the person managing the care of the catheter may observe the patient for signs of septic, mechanical or phlebotic complications of the central veins.



## Conclusion

We feel that hyperalimentation may be performed in a community hospital with excellent results and minimal complications outside of an intensive care unit environment. Careful attention to catheter insertion, strict catheter care, and close metabolic observation of the patient makes hyperalimentation possible in the community hospital. ◀

## Addendum

Since this article was accepted for publication we have performed hyperalimentation on another 50 patients. We have formed a nutritional support service made up of physicians, nurses, dietitians, pharmacists and physical therapists. Our protocols and equipment have become more standardized and our indications have expanded to include pre-op and intraoperative hyperalimentation when nutritional status evaluation dictates. We have added the Broviac long term central venous catheter to our armamentarium.

Our new level of sophistication does not negate the primary message of the article—that central venous hyperalimentation can be performed in the community hospital safely and successfully.

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# Neuropathy and Nerve Conduction

BY PAUL E. KAPLAN, M.D./CHICAGO

*While neuropathy manifests otherwise unrelated diseases, evidence of neuropathy can be demonstrated objectively using nerve conduction velocity (NCV) techniques. NCV involves delivering a pulse or wave of electrical energy to the nerve's axon trunk to be studied. The evoked potential may then be monitored at two different places along the nerve trunk. At each site, the height or amplitude can be recorded in millivolts or microvolts, the duration recorded in milliseconds, and the number of phases noted. In addition, the time latency may be recorded at each site in milliseconds. These are four parameters observed during NCV studies. The evoked potential recorded of the muscle response to direct stimulation is the M wave.*

Nerve conduction velocity studies are indicated as auxiliary aids in the confirmation of entrapment neuropathies. Carpal tunnel syndrome, neuropathy of the ulnar nerve at the elbow, and neuropathy of the peroneal nerve at the head of the fibula are three examples of entrapment neuropathies.

Peripheral neuropathies are very common complications of diabetes, renal failure, rheumatoid arthritis, or amyloidosis. NCV studies are valuable in these disorders and also when Guillain-Barre Syndrome, Friedreich's Ataxia, Bell's Palsy, alcoholism, or lead poisoning is suspected.

## Nerve Conduction Velocity

Nerve condition velocity may be obtained by dividing the distance between two points by the difference in time latencies. The time latencies and nerve conduction velocities are only one of four parameters that may be monitored at the

recording sites. Motor NCVs may be obtained by placing the recording electrode in muscle innervated by that nerve. Sensory evoked potentials may be recorded from the nerve itself. When the stimulation and recording of evoked potentials follow the direction that nerve impulses usually take down the nerve, those techniques are said to be orthodromic. When the stimulation and recording of evoked potentials travel against the direction that the nerve impulses would ordinarily take, those techniques are said to be antidromic.

Nerve conduction generally depends upon an intact myelin sheath surrounding the nerve axon. When the nerve axon is damaged but the myelin sheath remains intact, nerve conduction may not be affected. However, when the nerve is involved in an inflammatory process so that myelin sheath degenerates (Wallerian degeneration), then nerve conduction will slow. This slowing will become observable as early as two days after degeneration has begun. These changes may develop even if Wallerian degeneration does not take place—as in the neuropraxic nerve.

Standardized techniques have been developed for motor and sensory conduction over many of the nerves in the upper and lower extremities. These nerves include the median, ulnar, posterior tibial, peroneal, femoral, and radial nerves. Sensory and motor, orthodromic and antidromic techniques have been described in detail. Special techniques for the sciatic and lateral femoral cutaneous nerves have been noted. In these various techniques, two types of stimulation may be used—surface stimulation and needle stimulation. Peripheral facial nerve paralysis may be followed with serial motor latencies.



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of the department of rehabilitation medicine at Northwestern University, he is also immediate past vice president of the Illinois Society of Physical Medicine and Rehabilitation. Further accomplishments include fellowships in the Academy of Physical Medicine and Rehabilitation and the American College of Physicians.



Table 1

## Nerve Conduction Mathematics

Nerve Conduction Velocity = (Meters/sec)	Distance Between Stimulation Sites	Time Latencies Difference
Expected Term. Latency = (Msec)	Distance From Wrist Stimulation Site to Muscle	Nerve Conduction Velocity
Residual Latency = (Msec)	Observed Terminal Latency— Expected Terminal Latency	

## Stimulation Techniques

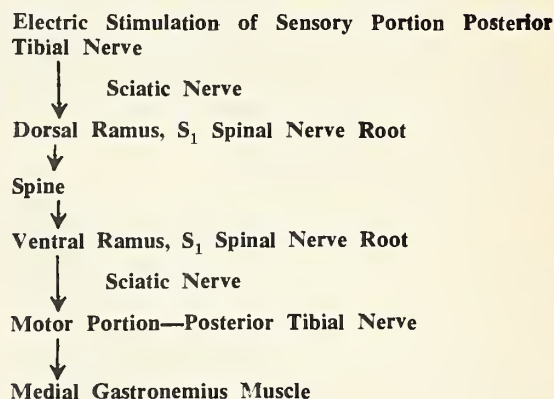
Needle stimulation locates the exact point on the specific nerve to be stimulated more precisely than surface stimulation techniques. Surface recording electrodes have the advantage in motor NCV of monitoring a consistent size and shape of the motor-evoked potential. With needle recording electrodes used in motor NCV, the size and shape of the motor-evoked potential may change with a very small change in needle position.

The amount of electrical energy required to stimulate the nerve provides a fifth observable parameter. One of the very early signs of neuropathy is elevation of the electric stimulation threshold. Therefore, more and more electric energy will be needed to stimulate that particular nerve. As nerve conduction velocity proceeds from the proximal to the distal extremity, the NCV slows materially. The amount of that slowing may be measured as residual latency (Table 1). These measurements reflect the state of delicately tapering nerve fibers distal to the patient's wrist and ankles. As the nerve conduction velocity slows and the motor and sensory evoked potentials become abnormal in size and shape, so does the residual latency increase. Of the five parameters, among the earliest to become abnormal are those involving the size and shape of evoked potential.

Evoked potentials can be compared with those recorded in the same nerve in the other extremity and also with results given in studies using standardized techniques. It is important that the electromyographer performing nerve conduction velocity measurements be very precise and have a thorough knowledge of electrophysiology. In certain very deeply placed nerves, and in nerves moderately or severely involved with peripheral neuropathies, needle stimulation techniques may be required. The importance of

Table 2

## H — Reflex



a meticulous and exacting approach in this area is very great. However, the importance of the standardized techniques that have been detailed in the past 10 years cannot be minimized. These standardized techniques allow one electromyographer in one part of the country to reproduce the technique of an electromyographer in a completely different part of the country. Under certain circumstances, reproduction of nerve conduction values within 2-5% may be obtained from day to day in the same patient.

Anomalous innervation may also present a challenge. In some patients, a forearm connection between the ulnar and median nerves causes the ulnar nerve at the wrist to hold nerve fibers innervating the thenar eminence. Blocking the ulnar nerve temporarily and repeating the median nerve conduction velocity studies will help clarify the situation.

## Reflexes

Electric stimulation to a nerve produces electric impulses which are sent proximally up the nerve trunk as well as distally. The evoked potential generated when the impulse travels proximally up the nerve to the spinal cord and back distally to the recording muscle is the F wave. It can be elicited in commonly evaluated nerves, such as the ulnar, median, and peroneal. Unilateral proximal neuropathies such as brachial plexus injuries can prolong the F wave on that side when compared to the unaffected extremity. The F wave might in these instances even be absent.

The H reflex is formed when the impulse travels proximally through the dorsal ramus,

spinal cord, ventral ramus, and distally to the recording muscle (Table 2). It is commonly found in adults only in the posterior tibial nerve unless special techniques are used. In the posterior tibial nerve, it is the electrophysiological equivalent of the ankle jerk. As such, it is absent or prolonged in such diseases as sciatic neuritis and S1 radiculopathy.

### Further Diagnostic Applications

In anterior horn cell diseases like poliomyelitis or amyotrophic lateral sclerosis, sensory nerve conduction velocity values will be unremarkable. This situation is also true for spinal cord injuries not involving the dorsal ganglion and for nerve root avulsions not involving that ganglion. A normal NCV value in these conditions will help differentiate them from the polyneuropathies and from Guillain Barre Syndrome.

In myopathies, the motor evoked potential will often be brief and reduced. However, latency and conduction velocity values will be unremarkable. Finally, special repetitive stimulation studies will be required to confirm the presence of myasthenic syndrome or myasthenia gravis.

### Electrotherapeutic Options

In the past forty years, electrostimulation has been used to treat denervated muscle. It has been thought to retard the rate of neurogenic atrophy and to promote recovery. It has also been thought to increase the relative number of Type I muscle fibers after induced isometric contractions. Certain specific conditions must be met. The induced contraction must be strong and the muscle relatively small. The treatment should be given frequently. As a result, home instructions and equipment is optional and should be part of a comprehensive treatment of specific single nerve lesions.

Electrostimulation may also be used to relieve chronic pain of neural origin. Very brief, rapid pulses are applied to a large area of the muscle. These afferent sensory impulses are thought to block painful stimuli at the spinal level. These therapeutic applications of electric stimulation should be administered as part of a comprehensive rehabilitation program.

Work in this area is continuing. More advances in electrotherapeutic options may be expected within the next five years. ◀

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# Library Networking and CME

BY MYRTLE SMARJESSE, NANCY STUMP AND KENNETH H. SCHNEPP, M.D./SPRINGFIELD

*Continuing Medical Education (CME) for high quality patient care and for license renewal depends largely on access to resources—namely, the hospital library and, behind the scenes, the library network system. Illinois physicians practicing in small hospitals are at a disadvantage. About 26 of the 71 hospitals in central and southern Illinois provide library services. By an Act of Congress in 1965, library networking was developed to meet the needs of the practicing clinician but a recent funding decrease might affect future development. The Capital Area Consortium (CAC), along with other library consortia throughout Illinois, are willing and eager to meet the challenge of providing resources to the rural health professional.*

*The purpose of this paper is to discuss the importance of the hospital library and the library networking system to continuing medical education with particular reference to the small hospital.*

The last decade has seen an increasing pre-occupation on the part of health providers, consumers and legislative bodies with continuing medical education (CME). On last count, 13

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states had passed legislation requiring proof of some sort of approved educational experience on the part of physicians before re-registration or re-licensure would be granted.<sup>1</sup> The specialty societies are increasingly moving in the direction of periodic re-examination for continuing certification.\*

This trend has caused a number of problems, particularly in rural and sparsely populated regions where medical care might be furnished by one or two physicians. The absence of these practitioners for several days at a time, while fulfilling legislative requirements for license renewal, could be a real hardship on patients. The Illinois legislature clearly recognized this at the time of adding CME Sec. 5.1 on July 1, 1976 to the Illinois Medical Practice Act. At the very end of this section is the statement, "the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality."

It is perhaps an unpleasant thought to realize that, as late as a decade ago, about one-half the people of the State of Illinois could be attended by physicians with ready access to good medical libraries. In sharp contrast to this, the remaining citizens were expected to get along with physicians who had no such educational facilities or opportunities. This study was conducted to determine, if possible, the best way of promoting continuing medical education for, roughly, one-half the physicians of Illinois without undue disruption of medical services.

The proposed solution is to attempt to bring the instruments of continuing medical education to the physicians in effective and appropriate form. It must be emphasized that true continuing

\*Since this writing, legislative activity has altered the tally to show that 13 states now require CME for license renewal, 13 state medical societies require CME for membership and, in four states, CME is required by both groups.

education should have been inculcated in each physician during medical school and subsequent training. We have no doubt that this is true. Too often, however, the impetus is stymied within a few years of building a practice in an area devoid of literature resources. It becomes increasingly easier to refer a patient than attempt to solve an intricate diagnostic problem.

In the last analysis, continuing medical education is but a euphonious phrase which implies that the patient will receive the latest and most effective therapy available.

At least part of the answer must remain the problem of the small hospital library and library networking system. In Illinois there are 87 hospitals with less than 100 beds.<sup>2</sup> In general, these are the hospitals which experience financial troubles. Their boards of directors may take a dim view on annual expenditures for a medical library.

### **History of Library Networking**

In 1965, the Medical Library Assistance Act provided funding for the development of Regional Medical Library Programs. The purpose of the Act was to provide the nation's practicing clinicians, health researchers and students a rapid flow of bio-medical information in the latest diagnostic and therapeutic modalities.<sup>3</sup> Eleven regional libraries were developed throughout the nation to meet these goals through continuing educational programs for professional and non-professional librarians, resource sharing, consortia development and interlibrary loan cooperation. These programs were developed to help approximately 8,000 health institutions comprising over 7,000 community hospitals, over 550 colleges, universities and professional schools with medical, dental, nursing, veterinary, allied health and bioscience programs, and approximately 470 medical research societies, health care, business and industrial organizations.<sup>4</sup>

In 1967, the Midwest Region (now known as the Midwest Health Science Library Network, MHSLN), became a reality with the commitment to develop and encourage local resource sharing, with John Crerar Library as the designated Midwest Regional Library. In 1973, the Region decentralized into Resource Libraries in which Illinois houses three for the Region—University of Illinois Medical Library, John Crerar Library and Southern Illinois University School of Medicine Library.

These Resource Libraries became subcontractors for the National Library of Medicine in a document delivery service—interlibrary loans for

books, photocopies of journal articles and audiovisual material. The Midwest Health Science Library Network, serving more than 1,800 institutions in Illinois, Indiana, Iowa, Minnesota, North Dakota and Wisconsin, established an Interlibrary loan quota system. This quota system limited the number of free loans an institution could obtain through these designated Resource Libraries. In 1974, this Network initiated incentive programs to increase local cooperation. Additional free loans could be obtained through consortium development. Members in a consortium pooled their free loans, which allowed the larger institutions to use some of the free loans allotted to the smaller institutions. Additional free loans were given to a consortium on an award basis for sponsoring workshops, etc. The consortium also received additional free loans for sharing resources among its members. To give an example, the Capital Area Consortium, utilizing the incentive programs for fiscal year 1977/1978, received over 1200 possible free interlibrary loans.

### **Present System**

Since 1974, funding for the incentive based interlibrary loan program has decreased and accordingly, free loans have decreased from 50 to 11 per institution. The program was implemented in two phases. Phase One (May-December 1978) provided 11 free loans per institution and a drastic cut in the incentive program for obtaining additional free loans. Although, at this writing, Phase Two (January 1979-April 1979) was still in the planning, there will be a further reduction in free loans (possibly four per institution) with no incentive program for obtaining additional free loans. As one can see, large or small libraries will have to budget or charge their patrons for loans obtained from resource libraries. The estimated cost is \$3.50 per loan.

### **Future of the Hospital Library**

In 1975, there were a total of 7,156 hospitals in the United States. 4,298 (60%) of these hospitals were community hospitals with fewer than 200 beds.<sup>5</sup> Statistics vary as to how many of these hospitals have libraries, but it seems safe to say that less than 50% of these small hospitals have libraries and are providing library services. In central and southern Illinois, about 26 of 71 hospitals are providing library services.

In any institution or organization, the library is the main link in the ultimate fulfillment of information needs for continuing education, re-



**Table 1**  
**Objectives**

- I. *Adequate funding from the national and state levels in the areas of:*
  - A. Interlibrary Loans
  - B. Continuing Educational Programs
  - C. Consortia Development
  - D. Grants
  - E. State-Wide Sponsored Consulting Personnel
  - F. State Coordinator for Development of Library Services
- II. *Better communication system at the national and state levels to the:*
  - A. Institutional Governing Boards (Communication at their Levels)
  - B. Rural Physicians
  - C. Allied Health Personnel
  - D. Individual State Networks
  - E. Library Organizations
- III. *Effective resource sharing programs in the areas of:*
  - A. Interlibrary Loans—Consortia Interfacing
  - B. Reciprocal Borrowing Agreements—Consortia and Statewide
  - C. Development of Union List of Serials
  - D. On-Line Data Bases

search and patient care. In reviewing these statistics and evaluating the library network changes, one questions the future of small hospitals who have not yet developed a library or are in the process of developing a library. Technical information in the sciences and medical technology has grown so rapidly that physicians and allied health personnel cannot be expected to purchase every journal or textbook published. They must rely on the hospital library to meet their needs.

In December, 1977, the Joint Commission on Accreditation of Hospitals revised their standards for Professional Library Services in all accredited hospitals. The standards state: "The professional library services shall be organized to assure appropriate direction or supervision, staffing and resources," and "The provision of professional library services shall be guided by written policies and procedures." They further state, "The hospital shall provide library services to meet the information, education, and, when appropriate, the research-related needs of the medical staff."<sup>6</sup>

### Conclusion

It is our opinion that the availability of resources to health professionals in rural areas might be in jeopardy. Can a rural hospital of 55 beds and five staff physicians justify money allocated to a non-revenue department—the

hospital library? Can the clout of the medical staff persuade the administration and board of directors to establish a library? Will new standards developed by the Joint Commission on Accreditation of Hospitals have an impact on the governing boards in the small hospital? We hope the answer is yes, but we tend to be skeptical.

The Southern Illinois University School of Medicine, established in 1969, is endeavoring to meet the needs of rural communities in central and southern Illinois. It is their mission to educate physicians who will serve these areas. If resources are not available for these physicians to maintain their education in the ever-increasing technology of health care, the small hospitals in Illinois will not be able to retain the physicians or the high quality of health care needed.

There are existing health-related institutions willing to share resources and cooperate at all levels, if the funding and incentives are readily available. Presently the national level of funding to meet the needs of the small hospital library is inadequate. Cooperation and communication at the national and state levels are also inadequate. The Capital Area Consortium suggests that a definitive plan starting at the national and state levels with the cooperation and involvement of the library organizations (Medical Library Association, Special Library Association, American Library Association and individual state library associations) be developed. We feel that the following objectives (Table 1) will provide for the availability of needed resources for education, research and patient care in the rural areas, as well as meeting the ever-growing needs of other health-related institutions. ◀

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*A portion of this paper was presented at the Regional Pre-White House Conference, on June 10, 1978, at Urbana, Illinois.*

# Evaluation Of A Program For Weight Control For Obese Children And Adolescents

BY RAJENDRA CHOKSI, M.D., PAMELA BUNJE BOWER, A.C.S.W., VINCENT  
POLLARD, M.D., AND VIPUL N. MANKAD, M.D.,/CHICAGO

*Modification of dietary habits, nutrition education and an exercise program were utilized to control weight gain in 39 obese children and adolescents in an outpatient department in a community hospital. Only 43.5% lost more than 5 lbs., but 90% moved toward normal growth curves. Greater than half of the drop-outs continued to move in the direction of normality despite their inability to lose weight after leaving the program. Many participants in the program had a successful experience by slowing their rate of gain, though they may not have lost weight.*

*The physiological process of growth must be considered in evaluating any treatment program for obese children and adolescents.*

Although there are over 100 research reports on behavioral treatment of obesity, nearly all describe the results of intensive efforts of teams based in medical institutions with academic emphasis. Since obesity is an extremely common

problem in the United States,<sup>1</sup> there is a need for studies on relatively less expensive programs based in community hospitals, which can be used as models for other community based institutions, such as schools.

Our study describes the results of a program for weight control in adolescents referred to a small group of health professionals who consented to devote part of their time at the Mercy Hospital & Medical Center, Chicago, Illinois. The Mercy Hospital & Medical Center is located in an area of racially and ethnically mixed population. The study emphasizes the unique nature of the problem in a pediatric population, which requires an evaluation method incorporating the concept of growth as a normal physiological process.

## Materials and Methods

**Criteria For Selection Of Patients:** Patients between nine and 16 years, referred by primary care physicians, were accepted in the program after the diagnosis of obesity was confirmed by a pediatrician. Patients with grossly obese appearance and weight/height ratio at greater than the 95th percentile, using norms developed by the National Center for Health Statistics, were diagnosed as obese.<sup>2</sup> Endocrine and psychiatric illnesses were excluded by careful interview and physical examination. None were rejected on the basis of poor motivation or financial reasons.

**Therapeutic Methods:** A nutritionist and a social worker were major participants in the therapeutic team coordinated by a pediatrician. An occupational therapist, psychologist and physical therapist contributed as resources. The group met once a week for two hours on Wednesday afternoons. Parents and therapists were encouraged to participate in the program to control their own weight.

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**Table 1**  
**Comparison of Weight Loss and Movement to Growth Norms**  
**As Evaluation Methods in Pediatric Obesity**

<b>Groups</b>	<b>Number of Individuals With Weight Change in Pounds</b>	<b>Number of Individuals With Percent Change in Weight to Norm*</b>
Weight Loss	17 (43.5%)	27 (69.0%) Negative
Weight Increase	9 (23.2%)	4 (10.5%) Positive
No Change in Weight	13 (33.3%)	8 (20.5%) Negative
Total	39 (100.0%)	39 (100.0%)

\*Negative percentage change indicates movement of the growth pattern towards normal growth curves. Positive percentage change indicates movement away from the growth curves.

Weekly sessions consisted of: 1) group discussions, 2) group exercise programs and 3) group and individualized nutrition education using exchange system.

1) *Group Discussions*—Group discussions were organized with the objective of allowing each participant to share the experiences of others. Efforts made by each individual in weight control were discussed. Suggestions consisted of (i) restriction of meals to the breakfast, lunch and dinner, (ii) restriction of meals to dining area only, (iii) increasing activities which require active participation such as, gardening, sports, etc., and (iv) decreasing passive activities, such as viewing television.

2) *Group Exercise Programs*—Group exercise programs emphasized simple activities which can be continued at home, such as bicycle riding.

3) *Group and Individualized Nutrition Education Using Exchange System*—Each group received instructions in nutrition. Attempts were made to provide individualized counselling, to modify dietary habits without radical changes in meal composition. An exchange system was used to increase or decrease various components of the meals so that at least 25% decrease in caloric intake would occur.

A small reward was given to each patient each week for demonstrating desirable behaviors, such as regular attendance in the clinic, maintenance of dietary record, weight loss, and weight loss on consecutive visits. Rewards were proportionate

to the number and quality of desirable behaviors, which were scored by using a point system. Rewards were made from the fund created by a small contribution (\$5.00 per month) from participating patients. This was the only cost to the patient for attendance in the program.

Each month an Outstanding Weight Loser Award was given to the individual scoring maximum points.

#### **Evaluation Methods**

Results were evaluated using two criteria, 1) weight loss greater than 5 pounds, and 2) movement toward normal growth pattern. The latter was expressed as percentage increase or decrease from original weight toward 95th percentile weight for chronological age.

Participants in the program and those who had dropped out of the program were evaluated two months after the study period (15 months) as part of a short term, follow-up evaluation.

#### **Results**

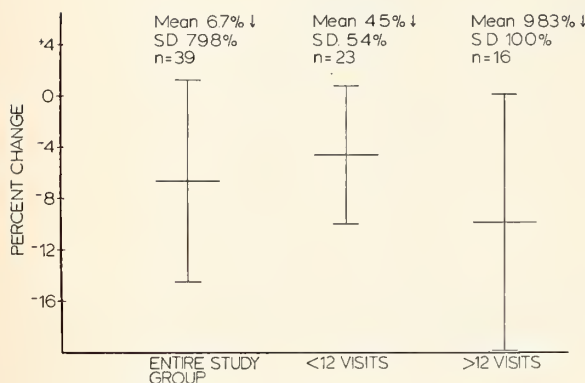
A total of 39 patients with an age range of nine to 16 years were followed over a period of 15 months. There were 33 females among the group.

Weight loss and movement toward growth norms are compared as evaluation methods in Table 1. The number of participants demonstrating movement toward normality is greater than the number showing weight loss.

Movement toward norms is examined in relation to the number of visits in Figure 1. Al-

**Figure 1**

Movement to Normality as Weight Change  
Expressed as Percent of 95th Percentile Weight



though movement toward norms was greater in the group with more than 12 visits, the difference did not achieve statistical significance.

Relationship between the performance during the study and during the follow-up period is shown in Table 2. All patients who succeeded in losing weight during the study continued to lose weight during follow-up if they continued to participate in the program. Only 14% of those who dropped out continued to lose weight during follow-up period ( $p < .001$ ). Fifty-seven percent

of drop-outs, however continued to move toward norms. The difference in movement toward norms between active participants and drop-outs is not statistically significant.

### Comments

Physiological growth processes must be considered while evaluating any treatment program for obese children and adolescents. Children may not lose weight while successfully controlling the rate of weight gain. This concept, to our knowledge, has not been emphasized in the literature on obesity. Weight loss and measurements of adipose tissues may be appropriate for evaluation of an obese adult. Vast differences between the number of weight losers and those demonstrating movement to growth norms in this study indicate the need to include both methods in evaluation of the obese child.

Results of our program, which utilized minimal specialist time, are similar to many studies on obesity using weight loss as the criteria for evaluation. Proportion of patients losing 20 pounds varied between 12-29% in studies reviewed by Stunkard.<sup>3</sup> Forty-one percent of participants in the program described here lost more than five pounds. Proportion of successful weight losers was significantly greater in the group of individuals with more than 12 visits. All patients (100%) moved toward growth norms within 12 visits.

Poor compliance and high drop-out rate are consistent problems in obesity programs. It is

**Table 2**  
Comparison of Active Participants and Drop-Outs  
on Follow-up Examination

	Number of Patients In The Group	Number of Patients Who Lost Weight During the Program	Number of Patients In Follow- up Exami- nation	Number of Patients Who Main- tained Reduced Weight	Number of Patients Who Moved Towards Normal During Program	Number of Patients Who Con- tinued to Move to Normal During Follow-up
Patients Active in the Program During Follow-up	12	9/12 (66%)	12/12 (100%)	9/9 (100%)	9/12 (66%)	9/9 (100%)
Patients Discon- tinuing the pro- gram During Follow-up	27	7/27 (25%)	15/27 (55%)	1/7 (14%)	18/27 (54%)	8/14 (57%)
Total	39					



encouraging to know that greater than half the drop-outs continue to move in the direction of normality despite inability to lose weight after leaving the program. Results of programs for obesity vary considerably because of such factors as patient selection, evaluation methods, motivation and other population characteristics. Due to these complexities, results of our program may not be duplicated in other situations. Studies on weight control programs using similar teams of nutritionists and social workers or psychologists in schools would be interesting ◀

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### Acknowledgements

Jim Cussane and Patricia McMullin provided technical assistance.

## Viewbox

(Continued from page 213)

The history of four months' striking pains in the right thigh and leg is complemented with the neurological examination that showed minimal motor weakness in the right lower extremity. A lumbar myelogram (metrizamide), showed extradural defects compressing—medially the spinal canal, at the level of L4-L5 and L5-S1 (Fig. 1, A and B). Marked thickening of the above mentioned roots is seen in Fig. 2, A and B.

All of these pathological features are confined almost completely to the right side, but some abnormal early changes are also demonstrated on the left side. The possibility of a slight intradural component was entertained.

Neurofibromatosis is a good possibility, but the fact that there are no rounded or meniscal defects underneath the sheaths of the involved roots, a very typical feature in this disorder, makes this an unlikely diagnosis.

Herniated disk causes extradural defects and can amputate roots and produce the clinical picture described in this patient, but the fact that this disorder causes regular, well defined extradural compressions usually at only one intervertebral space makes it a remote possibility.

Epidural lipomatosis, ordinarily caused by excessive endogenous or exogenous adrenal glucocorticoids; even though it is a very rare disorder, can cause extradural compression and even spinal stenosis due to the amount of fatty tissue

accumulated in the epidural space, causing sometimes complete extradural block. In our case the evidence of extra and intradural component makes this possibility unlikely.

In arachnoiditis, multiple and more extensive irregularities are expected and not necessarily canal deformities or thickening of the roots, but in some cases involvement and amputation of these could be seen. Again, this is not a good possibility.

Seeding chordoma or local extension, as described recently, may resemble the radiological picture of the present case, but the bone structures appear grossly intact, unlikely in lumbosacral chordoma, well known as a bone destructive lesion.

This patient was surgically explored and a biopsy taken from the mass in the spinal canal reported a well differentiated histiocytic lymphoma, infiltrating the spinal canal. Further studies have not yet demonstrated evidence of the disease somewhere else.

This is a very unusual manifestation of primary lymphoma of the spinal canal, despite the fact that malignant tumors of the lymphoreticular system may involve the central nervous system as part of a generalized process, rather than a primary manifestation of the disease. The latter form is usually manifested by one or several tumoral masses within the glial substance, designated grossly as microgliomas or reticulum cell sarcomas. Spinal and meningeal lymphomas are exceptionally the site of primary lymphomas. In our case, however, the radiological features, manifested by diffuse thickening of the nerve roots with extra and intradural component, should point toward an infiltrating process. ◀

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## How To Conduct A Meeting

BY EUGENE DIAMOND, M.D./CHICAGO

It is likely that many complaints about frequency of hospital staff and committee meetings could be corrected by improving the quality of the meeting. For this reason, a basic set of rules and regulations should be agreed upon. For most staffs, there will be a prior agreement. The Roberts Rules of Order are a popular protocol for the conduct of the meetings. Roberts Rules of Order date back to the late nineteenth century, and they are basically a set of rules which may be established by gentlemen's agreement for maintaining a decorum and proper procedure at any meeting.

The first rule of meetings is to start promptly. A limiting factor is the presence of a quorum. A quorum is defined as the minimum attendance necessary to transact business. The quorum may vary from one organization to another, and is determined by the constitution or the bylaws of the particular organization. *Ex-officio* members of any group are not counted in determining the quorum. In the case of the medical staff committees, the usual definition would be a majority of members. In a larger group, such as hospital staff that meets infrequently, a lesser number or a lesser percentage of members may be used in determining a quorum. It would be difficult at any given time to achieve the presence of majority of members from a large hospital staff. If a quorum is lost in the course of a meeting, the only action that can legally be taken is to act on

a motion to adjourn. If no one raises the question of the presence of a quorum, the debate can continue without taking any action. Much of what transpires in any meeting is informational only, so that it is not always necessary to adjourn a meeting entirely once the quorum is lost. That portion of business which does not require a vote or an action can still be transacted.

### Presiding Officer

The presiding officer has five basic duties: (1) to call the meeting to order; (2) to preside at all meetings; (3) to announce the business before the meeting in the proper order; (4) to state properly all questions brought before the assembly; and (5) to preserve order and decorum.

Insofar as possible, the chairman should remain objective. In a situation where the presiding officer has strong feelings on an issue which he wishes to express, he may appoint a temporary chairman and leave the chair in order to speak out on a question. The chairman has a right to vote whenever his vote will affect the result. He can vote in the affirmative to break a tie, or he can vote in the negative to create a tie and thereby defeat a measure. Tie votes lose in general, unless they occur in appeal of a ruling of the chair. In this case the tie vote sustains the ruling of the chair, since such a ruling can only be overturned by a majority of members.

### Voting

The usual form is voice vote, in which there is a call for the ayes and nays, and the chairman rules as to which has prevailed. If the voice vote is not clear, a member can call for a "division of the assembly," in which votes are cast individually and recorded. Ballot voting can be requested by a majority of the group. On most hospital staffs, the only required ballot voting

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would be for the elections of officers. When the nominating committee comes forward with only one candidate for each office or for an individual office, and the bylaws require the vote to be by ballot, it is permissible to authorize the secretary to cast a unanimous ballot for the single candidate. This must, however, be a unanimous decision of the assembly without any dissent.

A majority vote carries all motions with eight outstanding exceptions which require a two-thirds majority. These motions are in general those which have the effect of changing or suspending the rules. The eight motions requiring two-thirds majority can be separated into two groups of four.

The first group of four motions are those that make it easier for a group to take up a particular question. These motions are: (1) to take up a question out of order; (2) to make a special order (to suspend all rules which prevent the consideration of a particular question at a particular time); (3) to suspend rules; and (4) to amend the rules (this requires a special order and usually requires previous notice).

The second group of four motions requiring a two-thirds majority are those which have the effect of forcing an assembly to take final action on the question without allowing discussion. The two-thirds majority is required because this is contrary to the fundamental principle of deliberative bodies. This pertains to motions: (1) to limit debate; (2) to close debate; (3) the previous question (in other words to move a vote on the question already before the assembly); and (4) an objection to the consideration of the question.

Most of these motions requiring two-thirds majority are stratagems which can be avoided by eliminating any autocratic activity on the part of an intolerant chairman. These types of motions can also be the outgrowth of poor debaters or persons who are enamoured of the sound of their own voices.

Motions can in general be classified according to their order of precedence.

### **Privileged Questions**

Due to their importance, these motions take precedence over all others. Because of this privilege, they are undebatable. These motions are: (1) to fix the time of adjournment; (2) to adjourn; and (3) a question of privilege.

This kind of motion relates to the rights and privileges of an assembly or a single member of the assembly. A question of privilege can inter-

rupt a speaker. The chair rules as to whether or not this is as a matter of privilege. Two members can appeal the ruling of the chair, requiring a vote to override the ruling of the chair.

### **Incidental Motions**

*A point of order*—This takes precedence over the question giving rise to it, and must be decided by the presiding officer without debate. If the decision of the chair is appealed and seconded, a vote must be taken. The speaker resumes after the issue is decided either by ruling or vote.

*Objection to consideration of a question*—This must be made when the question is first introduced, before the debate. This motion requires a two-thirds majority vote.

*Reading papers*—Members can ask that a document be read before voting on it.

*Withdrawal of a motion*—If no one objects, this motion is granted by the chair. If there is any objection, it requires a majority vote on leave to withdraw.

*Suspension of rules*—This motion is not debatable, not amendable, and no subsidiary motion can be applied to it. Rules should not be suspended except for specific good purpose.

### **Subsidiary Motions**

*Lay on the table*—This motion takes precedence over any other subsidiary question and yields to any privileged or incidental motion. The effect is to postpone for future sessions. This motion is not debatable, and can interfere with the rights of a minority.

*Previous question*—This motion takes precedence over even debatable questions. This motion is not debatable or amendable.

Members may submit a resolution and at the same time move the previous question thereon. (Steamroller tactic). It is also in order to move to lay a question on the table or to move to adjourn before final action is taken (Anti-steamroller tactic). Such motions are used to postpone to a certain day, to send to a committee, to postpone indefinitely or to amend.

These apply to all motions except motions to adjourn, lay on the table, postpone indefinitely, reconsider or call the previous question.

### **Terminating A Meeting**

Most committee meetings should end in one hour. Most staff meetings should end in two

**Table 1**  
**Simplified Chart of Motions**

Motion	Purpose	Debatable	Amendable	Priority*	Vote
<b>PRIVILEGED MOTIONS: Require immediate action because they involve personal rights</b>					
Adjourn	Close Meeting	No	No	(1)	Majority
Recess	Interrupt meeting	No	Yes	(2)	Majority
			(as to time)		
Question of privilege	Assert Rights	No	No	(3)	Chair Rules
<b>SUBSIDIARY MOTIONS: Motions used to dispose of or change main motions</b>					
Place on the table	To put aside or postpone	No	No	(4)	Majority
Order previous question	Close debate	No	No	(5)	Two-Thirds
Postpone to a definite time	Delay action	Yes	Yes	(6)	Majority
			(as to time)		
Refer to a committee	Needs more study	Yes	Yes	(7)	Majority
Amend	Change or modify	Yes	Yes	(8)	Majority
<b>INCIDENTAL MOTIONS: Motions that arise during debate; are readily settled</b>					
Point of order	Assert Rights	No	No		Chair Rules
Point of information	Request information	No	No		Chair Replies
Appeal the decision of the chair	Assert Rights	Yes	No		Majority
Parliamentary inquire	Request to clarify rules	No	No		Chair Replies
Nominate	Elections	Yes	No		Majority
<b>PRINCIPAL MOTIONS: The final action to be taken; or a change of mind</b>					
Main Motion	To propose new business	Yes	Yes	(9)	Majority
Special order of business	To speed action	Yes	Yes		Two-Thirds
Reconsider	Change a decision	Yes	Yes		Majority

\*PRIORITY (precedence): The right of one motion to be considered before another

hours or less. The worst enemies of an orderly meeting are verbose or irrelevant debate, failure to synopsize committee actions, failure of presiding officer to use legitimate means to limit debate and failure to adhere to the agenda.

Complaints that there are "too many damn meetings" may be attributed to a variety of staff malfunctions:

*A proliferation of standing committees.* Where possible committees should be combined or phased out by a committee on committees. Ad hoc committees should be employed for minor issues and discharged when the issue is settled.

*Unreasonable requirements for meeting frequency.* For example: Bylaws committees or entertainment committees should only meet when there is business to transact.

*"Drone Syndrome."* Hardworking, efficient staff members are given numerous committee assignments. "Queenbee" members are excused because they are unreliable. Bylaws attendance requirements should solve this problem.

*"Squeaky Wheel Gets the Grease."* Chronic complainers are assigned to transact business in an area where they chronically complain. This measure, although it may seem an appropriate form of retaliation against harassment, usually leads to bias or inefficiency in the conduct of the business of the staff.

*Failure to use subcommittees appropriately.* For example: to review deaths or to do audits outside of the formal committee meetings, thereby bogging down meetings with details and minutiae, which could be more appropriately taken care of by a smaller group.

Probably the best way to provide for improved quality of meetings would be to give some basic indoctrination to new staff officers and chairmen on a regular basis. It can not be safely presumed that someone without previous experience will have the skills necessary to carry out all the functions of a presiding officer.

Table one consists in the summary of motions and their proper dispositions in an efficiently conducted meetings. ◀



## Report of Four Cases

# Soft Tissue Infections Due to *Mycobacterium Kansasii*

BY WILLIAM S. YALE, M.D., THOMAS A. RUDD, M.S., M.D., AND  
WILLIAM B. STROMBERG JR., M.D./CHICAGO

*After Robert Koch identified Mycobacterium tuberculosis in 1882, Max Pinner<sup>1</sup> described a phenomenon in 1935, which had been noted several decades earlier: "atypical" but seemingly saprophytic mycobacteria were being isolated from human sputum specimens producing non-typical tuberculoid lesions in guinea pigs. Pinner classified 15 of these organisms and suspected they occasionally produced pulmonary disease in man. In 1953, at the University of Kansas, Victor Buhler<sup>2</sup> confirmed that one of these organisms, his "yellow bacillus" which later became known as Mycobacterium kansasii, had produced fatal pulmonary lesions in man. By 1959, Ernest Runyon<sup>3</sup> classified the atypical mycobacteria into four groups, M. kansasii being one of two pathogens (M. marinum the other) in class I, the photochromogens.*

Textbooks of infectious disease<sup>4,5</sup> describe *Mycobacterium kansasii* as an increasing cause of pulmonary disease with definite clustering in the central and southern

United States. In Cook County, it accounts for up to 7% of admissions to tuberculosis sanatoria.<sup>5</sup> Approximately 15% annually of suspected tuberculosis cases in Dallas

County hospitals have proven to be *M. kansasii*.<sup>6</sup> However, extrapulmonary manifestations of this disease are considered extremely rare. In recent years, occasional articles<sup>7-11</sup> have reported one or two cases of this organism causing primary soft tissue infections (via cutaneous or mucosal penetration) in seemingly healthy individuals.

In addition to the following cases, personal communication with other physicians in the Cook County area has revealed four other instances of joint (one elbow, one wrist, two knee) infections due to *M. kansasii* (recovered in culture) in normal subjects.



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## Case Reports

Between 1968 and 1976, four such cases were encountered in the mycobacteria laboratories of Northwestern Memorial Hospital. A fifth patient from Kansas clinically resembling cases one and two is not presented as no pathogen had been isolated. This patient's left index finger tenosynovitis was treated successfully with INH-ethambutal. All routine laboratory data, chest X-rays, and physical findings were within normal limits

steroid injections, penicillin therapy, or tenolysis. Culture of the surgical specimen identified *M. kansasii*. Within six months of treatment with INH and rifampin his finger improved and gained nearly full range of motion.

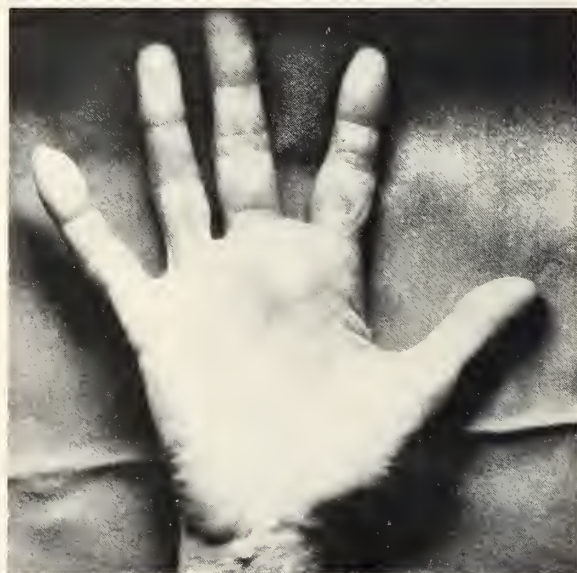
### Case II

A white housewife attempted to remove a "black speck" from her right index finger with a pin and initiated a slowly destructive process of her index and middle fingers

been isolated and twice required debriding procedures. When a positive auramine stain was obtained on a tissue specimen, treatment with a combination of PAS, INH and myambutal was initiated. The tissue culture grew *M. kansasii* at two weeks. Her hand had improved by the third month of treatment and she has had a reconstructive procedure on her hand.

### Case III

A 54-year-old white male com-



Figures 1 & 2

Case II, 1½ years after onset of symptoms and after a fourth injection of steroid into the index finger's flexor tendon sheath, developed a massive swelling for which she was hospitalized 12 days and treated with antibiotics.

in the following patients unless otherwise noted.

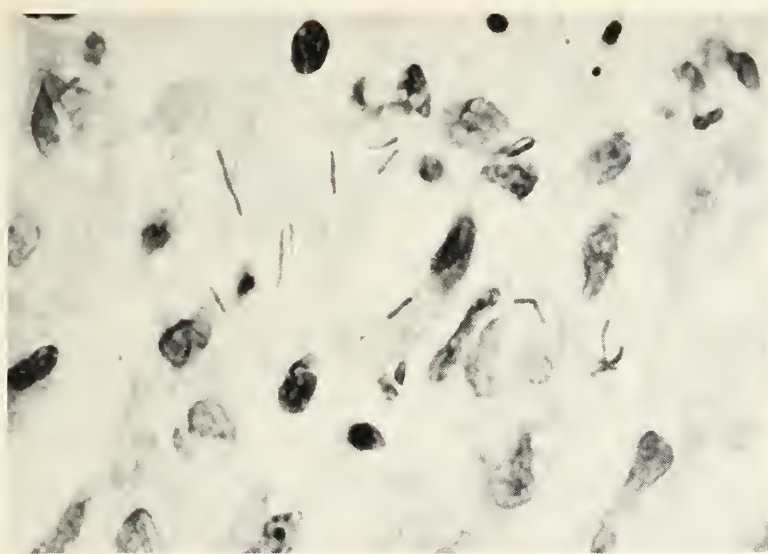
### Case I

A white male Kansas farm laborer incurred a small laceration of the middle finger on a piece of farm machinery. The middle joint and extensor tendon progressively became swollen over the next four months, not improving with local

and lateral palm. Before the proper diagnosis had been made (eight months later) she was treated with warm soaks, flexor tendon synovectomy, five thiotepa-steroid injections and three hospitalizations. The patient had been placed on antibiotics up to a month at a time for febrile episodes of draining hand infections from which no specific pathogen had

plained of two years' left "weak grip" and hand numbness. A mild volar wrist swelling was noted and his symptoms improved after a carpal tunnel release. Three years later the patient returned with the same complaints and a more prominent wrist swelling as well as destructive carpal joint disease seen on X-ray. The second debriding procedure, performed within three





**Figure 3:** The beaded red rods of *M. kansasii* as they appear on an Auramine-o stain. The stain is diagnostic of mycobacterium and yields fewer false positives than the Ziehl-Neelsen stain.

months after a first debridement, revealed *M. kansasii* on a culture of synovial tissue. The patient's wrist has improved slowly on INH and Rifampin.

#### Case IV

A 36-year-old Asian housewife consulted a plastic surgeon for a 3x2x1cm. mass in her left submaxillary gland present for "several months." Several "cervical" lymph nodes were palpable. *M. kansasii* had grown on culture at three weeks and was also identifiable on auramine stain of the excised gland. She had no recurrence of symptoms after surgery and has been treated with INH and PAS.

#### Discussion

*Mycobacterium kansasii* is an infrequent, primary infecting agent of soft tissue in otherwise apparently healthy persons. It often appears as an indolent infection of tendons and adjacent tissue without primary cutaneous involvement. At surgery, the resected lesions vary in appearance from nearly normal tissue with slightly thickened tendons

and increased synovium to extensive, nearly liquid, mucoid material with dissolution of soft tissue, tendons and joint capsules. The material at times is bloody, but on four occasions had been clear yellow containing numerous particles resembling small grains of rice. Microscopically, all tissue specimens demonstrated destructive granulomatous lesions usually with caseation (highly suggestive of fungal or mycobacterial origin).

Diagnosis is often delayed and is best achieved by submission of excised tissue for mycobacterial cultures and histologic studies. Aspirated fluid and swabs of wounds are not as satisfactory in providing the diagnosis. Tissue cultures for mycobacteria are placed routinely on Lowenstein-Jensen and on 7H10 media both incubated at 37° with a reliable recovery rate of the organisms; the usual period for appearance of *M. kansasii* growth is 10 days. The histologic sections are stained by the Ziehl-Neelsen and Auramine-O procedures. The organism is speciated by

its colonial morphology, photoreactivity and its ability to reduce nitrate and hydrolyze Tween-80 and urea.

Cortisone injected into these lesions is decidedly not beneficial. Therapy is begun with INH, 300 mg. and Rifampin, 600 mg. daily for a minimum of 18 months adding a third drug if sensitivity studies demonstrate a strong resistance to either of the initial drugs. ◀

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## IDPH Announcement of Data Collection

# Pregnancy Termination Complications Report Form Implemented

*The IDPH Division of Hospitals and Acute Care Facilities has asked that IMJ inform Illinois physicians of a new form recently printed in response to Public Act 81-226, which requires reporting of complications occurring as sequelae of pregnancy termination. The text of that communication is reprinted verbatim below, in conjunction with a sample copy of the form itself, which is available from hospitals and ambulatory surgical treatment centers.*

Public Act 81-226 mandates that "a report of each abortion performed shall be made to the Department on forms prescribed by it." Such report forms shall not identify the patient by name, but shall include, but not be limited to information contained therein.

"Such form shall be completed by the hospital or other licensed facility, signed by the attending physician, and transmitted to the Department not later than 10 days following the end of the month in which the abortion was performed.

"In the event that a complication of an abortion occurs or becomes known after submission of such form, a correction using the same patient identification number shall be submitted to the Department within 10 days of its becoming known.

"All information obtained by a physician, hospital or ambulatory health facility from a patient for the purpose of preparing reports to the Department under this Section shall be confidential and shall be used only for statistical purposes.

"All information obtained by a physician, hospital or ambulatory health facility from a patient for the purpose of preparing reports to the Department under this Section shall be available to the Department for inspection in its capacity as

a regulatory agency and for statistical and informational purposes in its capacity as a public service agency but shall not be disclosed publicly in such manner as to identify individual patients, except that the Department may disclose any information to another State agency required or authorized to conduct investigations of professional or business practices in hospital, ambulatory surgical treatment center, or other facility. State agencies conducting such investigations shall not disclose individual patient information publicly."

Forms are available on request from the Department of Public Health, Office of Health Regulation, Division of Hospitals and Acute Care Facilities, 525 West Jefferson Street, Springfield, Illinois 62761, telephone 217-782-7412, and at hospitals and ambulatory surgical treatment centers which perform terminations. We are sending a small supply of forms to each hospital and ambulatory surgical treatment center. Obviously, physicians can be supplied with forms from these settings. Completed forms should be sent to Mr. R. F. Bilstein, Administrator, Hospital and Ambulatory Surgical Treatment Center Section, Division of Hospitals and Acute Care Facilities, 525 West Jefferson Street, Springfield, Illinois 62761.



PREGNANCY TERMINATION COMPLICATIONS REPORT  
(USE THIS FORM AT TIME OF PATIENT DISCHARGE)

PATIENT INFORMATION

1. MEDICAL RECORD NUMBER

2. BIRTH DATE:

MO DAY YEAR

3. AGE

4. RESIDENCE OF PATIENT:

STATE COUNTY

CITY, VILLAGE

5. RACE: 1 ☐ WHITE 2 ☐ BLACK 3 ☐ ORIENTAL (CHINESE, JAPANESE) 4 ☐ AMERICAN INDIAN

5 ☐ OTHER, SPECIFY \_\_\_\_\_

6. MARITAL STATUS: 1 ☐ NEVER MARRIED 2 ☐ MARRIED 3 ☐ SEPARATED 4 ☐ DIVORCED 5 ☐ WIDOWED

7. PREVIOUS PREGNANCIES:

LIVE BIRTHS

OTHER PREGNANCIES

☐ NOW LIVING

☐ NOW DEAD

☐ SPONTANEOUS

☐ INDUCED

8. TERMINATION OF PREGNANCY PERFORMED

NAME OF FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, VILLAGE

ZIP CODE

COUNTY CODE

9. OPERATING PHYSICIAN'S NAME (IF KNOWN): \_\_\_\_\_

MO DAY YEAR

LICENSE NUMBER

10. DATE OF PREGNANCY TERMINATION: \_\_\_\_\_

MO DAY YEAR

11. COMPLICATIONS OBSERVED BY REPORTING PHYSICIAN:

01 ☐ HEMORRHAGE

02 ☐ UTERINE PERFORATION

03 ☐ SUSPECT UTERINE PERFORATION

04 ☐ CERVICAL LACERATION WITHOUT SUTURE

05 ☐ CERVICAL LACERATION WITH SUTURE

06 ☐ RETAINED PRODUCTS

07 ☐ TRANSFUSION GIVEN, \_\_\_\_\_ ml

08 ☐ BLEEDING REQUIRING CURETTAGE

09 ☐ SHOCK RELATED TO HEMORRHAGE

10 ☐ FEVER: 38° C./100.4 F. OR MORE  
24 HOURS OR MORE AFTER TERMINATION

11 ☐ FEVER REQUIRING ANTIBIOTICS

12 ☐ OTHER COMPLICATIONS (IF ANY) SPECIFY \_\_\_\_\_

13 ☐ DEATH, CAUSE \_\_\_\_\_

12. COMPLICATIONS REQUIRING HOSPITALIZATION: 1 ☐ YES 2 ☐ NO

IF YES: 1 ☐ OBSERVATION

2 ☐ MEDICAL TREATMENT

3 ☐ LAPAROSCOPY OR LAPAROTOMY

4 ☐ OTHER, SPECIFY \_\_\_\_\_

13. NAME OF FACILITY: \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, VILLAGE

ZIP CODE: \_\_\_\_\_

14. DATE OF ADMISSION: \_\_\_\_\_

MO DAY YEAR

15. DATE OF DISCHARGE: \_\_\_\_\_

MO DAY YEAR

16. IF APPOINTMENT FOR FOLLOW-UP VISIT, DATE OF APPOINTMENT: \_\_\_\_\_

MO DAY YEAR

17A. NAME OF PHYSICIAN TO WHOM REFERRED: \_\_\_\_\_

17B. LICENSE NUMBER \_\_\_\_\_

18A. PHYSICIAN TREATING PATIENT (TYPE OR PRINT NAME) \_\_\_\_\_

18B. ADDRESS: \_\_\_\_\_ CITY, VILLAGE: \_\_\_\_\_

18C. TELEPHONE NUMBER \_\_\_\_\_

18D. REPORTING PHYSICIAN'S SIGNATURE: \_\_\_\_\_

18E. LICENSE NUMBER \_\_\_\_\_

# Pulse of the ISMS Auxiliary



## Feet of Clay? Doctors Are People, Too

BY MRS. R. SAMUEL HOOVER, ISMSA

The first time the Illinois Auxiliary Board heard of "The Impaired Physician" was during a luncheon speech by Dr. James West in January of 1977. Before that time, not only had most physician's spouses not thought much about the subject, but the subject had never arisen openly as a problem or as a potential project for medical societies or auxiliaries. I can remember being amazed that there really was a documented problem of impairment, and that there were people willing to tackle the task of providing help to the troubled physician.

Several things come to mind when I think of that original description of impairment. First, how many impaired physicians there probably are. Second, what type of person the problem physician probably is or was. "There but for the grace of God, go we," seems an appropriate comment. They are not weak willed, skid row types, but serious, dedicated, highly motivated, intelligent, sensitive, perfectionists who somehow contracted a disease. Third, that it really is our responsibility to help the impaired physician. A doctor is too valuable a commodity to lose. Fourth, that the success rate of arresting the disease—for alcoholic and/or drug dependent physicians is very good—higher than the national average for similar disease. Finally, that a medical society pro-

gram to aid the impaired physician can help an impaired physician long before he becomes a danger to himself or his patients.

A lot of water has gone under the bridge since that lecture four years ago. The Illinois State Medical Society's Panel for the Impaired Physician has twenty-four members now, plus countless other willing advocates for the troubled physician. The times and attitudes are gradually changing; people are less reticent to admit alcoholism or drug dependency. People in general are gradually realizing that this is a *disease*—that alcoholism isn't funny or unspeakably awful. Changing attitudes is a slow process, but if the problem is not swept under the rug or locked behind closed doors, hopefully the social stigma can be eradicated. Old prejudices die so slowly, but there is hope developing with the numbers of "recoveries" now being discussed openly.

The Panel functions "as an act of good will, and the decision of the physician who elects not to accept offered help will be respected and held in strict privacy, except in instances where community welfare is at risk and in accordance with the principles and policies of ISMS."

"The Panel for the Impaired Physician of the Illinois State Medical Society exists to help that physician whose function is impaired by alco-



holism, drug abuse, physical or emotional problems which interfere with his/her ability to practice medicine. The Panel invites any physician or a member of his immediate family who wishes help or guidance in this illness to call a member of the Panel. A call for help will provide information, consultation, or a personal visit by a physician who is qualified to help, and who is able to offer counsel and referral to a treatment program, if indicated. The activity of the Panel is wholly voluntary. The illness of the person in need of help will be known only to the physician on the Panel who is called for assistance."

In Illinois, confidentiality is guarded highly. No names are recorded and no "head count" is published. The program has been expanded from an original emphasis on alcoholism and drug addiction to include any physician whose problems interfere with his ability to practice medicine. The Panel aids physicians who are mentally and physically handicapped.

For medical societies, medical staffs and auxiliaries, the ISMS offers a wide range of continuing education programs focusing on alcoholism detection and treatment. The Scientific Speakers Bureau will "tailor a program to fit the need" which could include speakers, panel discussions, and audio visual aids.

Those involved with the panel in Illinois believe that the program thus far has been a success. To continue to identify and to help rehabilitate physicians, state and national organizations have begun to work with medical students and residents. Most students and residents are unaware that they are at increased risk for mental and emotional impairment—not only during the time of their medical education, but later, as many young physicians develop lifestyles and inappropriate defense mechanisms which may lead to impairment. To prevent alcoholism and drug dependence by promoting a sense of well-being, some residents are working with medical schools and hospitals to improve working conditions. Doctors are people, too; both physicians and the community should see doctors as such. Like everyone else, they need time to relax, pursue leisure interests and maintain friendships. The 70-80 hour work week may not necessarily be good—and the young physician may be stressed too much and have unrealistic expectations regarding physical and emotional capabilities. This preventive aspect of impaired physician committee activity is becoming more and more evident.

Another area for consideration on the impairment scene is the involvement of the family,

specifically spouses. Medical marriages have recently come under much public and professional scrutiny. Some stress is inevitable in any marriage. When stress is continual, it may lead to psychosomatic illnesses, depression, alcohol and drug dependence on the part of husband, wife, or both. Vice versa, addiction could be a source of stress within the marriage.

A physician who is impaired often expends great efforts to maintain professional competence and performance. Long before professional activities are affected, however, the spouse may recognize signs of trouble. Depression and absenteeism in the physician may indicate marital problems. Some physicians are impaired, not because of their own illness initially, but because of impairment in their spouse. A physician can become so concerned about a spouse's behavior as to become ill.

The value of spouses in bringing impaired physicians into treatment cannot be overemphasized. The auxiliary can play an important role in increasing its members' awareness of impairment, the medical society's approach and the channels for seeking help. Programs can also be sponsored. They need not focus exclusively on impairment. Members may be more receptive to topic-oriented sessions on marital stress, financial planning, communication techniques and sexuality. Even if formal activities are not possible, auxiliary leaders should be aware of the medical society program and community resources.

The area of family therapy and family involvement is of course of particular interest to the auxiliary. Much can be done to offer emotional support. Possibly only a "listening post" is needed, or in some cases, knowledge and referral to other social agencies. This can be done on a personal level in the community, or on a state wide "panel" basis, to help preserve anonymity. This could be an area of auxiliary involvement in the 80's.

The Illinois Auxiliary has been active in sponsoring programs for education and awareness of the impaired physician and his problems. Panel brochures have been distributed throughout the state. The Auxiliary is aware of the problem and anxious to assist the Illinois State Medical Society in their continued efforts to aid the impaired physician. ◀

#### References

- The Panel for the Impaired Physician*, Committee on Alcoholism and Drug Dependence, Illinois State Medical Society.
- The Impaired Physician*, Department of Mental Health, American Medical Association.

# Obituaries

**\*\*Ailes, Arlington**, LaSalle, died January 21, 1980, at the age of 94. Dr. Ailes was a 1908 graduate of the University of Cincinnati Medical College.

**\*Baumgart, Edward T.**, Danville, died January 22, 1980 at the age of 68. Dr. Baumgart was a 1939 graduate of Rush Medical College.

**\*Brobst, C. D.**, Palm Desert, CA, formerly of Peoria, died January 30, 1980, at the age of 79.

**\*Cari, Joseph A.**, Chicago, died January 20, 1980 at the age of 66. Dr. Cari was a 1941 graduate of Chicago Medical School.

**\*Chiakulas, George J.**, Chicago, died January 20, 1980, at the age of 59. Dr. Chiakulas was a 1958 graduate of the University of Athens, Greece.

**\*Dreis, Doris**, Chicago, died February 10, 1980, at the age of 57. Dr. Dreis was a 1954 graduate of Johann-Wolfgang Goethe University in Frankfurt, Germany.

**\*Fukuda, Ippu**, Chicago, died December 30, 1979.

**\*Gilula, Adolph**, West Frankfort, died March 14, 1980, at the age of 74.

**\*\*Gross, John E.**, Chicago, died January 15, 1980, at the age of 85. Dr. Gross was a 1921 graduate of the Chicago Medical School.

**\*\*Heiberger, Charles Jackson**, Peoria, died March 3, 1980, at the age of 77. Dr. Heiberger was a 1929 graduate of Rush Medical College.

**\*Hummel, J. H.**, Joliet, died January 27, 1980, at the age of 57. Dr. Hummel was a 1950 graduate of the University of Chicago.

**\*Huss, Norman C.**, Assumption, died January 15, 1980, at the age of 63. Dr. Huss was a 1943 graduate of the University of Illinois.

**\*Janus, Arthur I.**, Oak Park, died January 30, 1980, at the age of 73. Dr. Janus was a 1940 graduate of the University of Illinois.

**\*\*Ledoux, Alfred C.**, Evanston, died December 16, 1979 at the age of 76. Dr. Ledoux was a 1929 graduate of the University of Boston.

**\*\*Lundstrom, Jacob H.**, Highland Park, died December 5, 1979, at the age of 82. Dr. Lundstrom was a 1927 graduate of the University of Illinois.

**\*Panepinto, John Joseph**, E. St. Louis, died September 14, 1979, at the age of 70. Dr. Panepinto was a 1942 graduate of Chicago Medical School.

**\*Patterson, Virginia Norrell**, Chicago, died March 5, 1980, at the age of 62. Dr. Patterson was a 1949 graduate of the University of Illinois.

**\*Pizarro, Antonio Jose**, Hillside, died February 11, 1980, at the age of 57. Dr. Pizarro was a 1949 graduate of the University of Havana in Cuba.

**\*\*Sauer, Louis W.**, Coral Gables, Florida, formerly of Evanston, died February 12, 1980, at the age of 94. Dr. Sauer was a graduate of Rush Medical College.

**\*Sharer, Robert F.**, Oak Park, died February 1, 1980, at the age of 75. Dr. Sharer was a 1931 graduate of Rush Medical College.

**\*Smith, Carlton R.**, Peoria, died March 10, 1980, at the age of 75. Dr. Smith was a 1931 graduate of Northwestern University.

**\*Stacy, George**, Chicago, died February 11, 1980, at the age of 67. Dr. Stacy was a 1943 graduate of Northwestern University.

**\*Watts, Harvey**, Peoria, died January 23, 1980, at the age of 57. Dr. Watts was a 1945 graduate of the University of Nebraska.

*\* Indicates ISMS member*

*\*\*Indicates ISMS member of the fifty year club*

## EKG

(Continued from page 217)

**Answers: 1. E 2. A**

The ECG rhythm strip is a standard chest monitor lead which is approximately the same as lead I in the twelve lead ECG. Inverted P waves at a rate of 72 beats/minute cannot be sinus in origin in this lead. Evaluation of the PR interval shows they are all equal and regularly followed by a dropped QRS. This is a type II second degree (Mobitz) atrioventricular block. The second beat in line one and the sixth beats in lines two and three are junctional escape beats with an RR cycle of 1520 msec. The QRS contour is slightly different from the conducted beats due to aberrant intraventricular conduction. There are occasional premature atrial beats which do not conduct to the ventricles. These P waves can be

seen following the first QRS in line one, the second P wave in junctional escape cycle in line two, and in the ST segment following the fifth QRS in line three. Although not conducted to the ventricles, they do affect the ectopic atrial rhythm. The ectopic atrial rhythm resets and then undergoes a warm-up phenomenon to get back to the rate of 72 beats/minute. Mobitz type II atrioventricular block is uncommon and often associated with a bundle branch block pattern. Our patient is rare in that his type II block is associated with a normal QRS duration and an ectopic atrial rhythm. The presence of a normal QRS with type II atrioventricular block suggests the disease is in the bundle of His. A permanent demand pacemaker was placed in the patient and his symptoms of lightheadness disappeared. ◀



# Doctor's News

**PHYSICIANS IN THE NEWS**—Newly elected medical staff officers for Westlake Community Hospital in Melrose Park are: **Alfred A. Akkeron, M.D.**, Bloomingdale, president, **Richard Zelazny, M.D.**, Bensenville, vice president, **John Tekla, M.D.**, Oak Brook, secretary and **Raul Lamas, M.D.**, Oak Brook, treasurer.

**AMA ANNOUNCES CME MEETING**—The AMA Council on Continuing Physician Education, in cooperation with the University of California at San Francisco School of Medicine and California Medical Association, will sponsor a three-day continuing medical education program on June 13-15 in San Francisco, California. "CME Designed for the Clinician," will include 15 courses for specialists in pulmonary disease, cardiology, infectious disease, internal and occupational medicine, allergy and immunology, ophthalmology, neurology and a wide variety of other specialties. Hour-for-hour Category 1 CME credit will be available to physicians. Reservations received by May 13, 1980, will be eligible for a group room rate. Further information may be obtained by writing the AMA Department of Meeting Services, 535 N. Dearborn Street, Chicago IL 60610; telephone (312) 751-6503.

**ISMS-SPONSORED TRAVEL PROGRAM**—The revised schedule of ISMS-sponsored travel programs for 1980 is as follows: June 8-21, Spain/Portugal; August 6-13, Switzerland; October 13-26, Peoples Republic of China; October 17-31, Western Mediterranean Cruise. Reservations cannot be accepted without the official form printed in promotional brochures which are mailed to all ISMS & Auxiliary members. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by the tour operator. Contact ISMS headquarters, 55 E. Monroe, Suite 3510, Chicago 60603, for additional information.

**MEDICAL STAFF: PHYSICIAN'S FRIEND OR FOE?**—is the title of an AMA seminar scheduled for April 24-25 at the Chicago Drake Hotel. The program will explore major conceptual and practical functions and roles of the medical staff. A special segment on risk management at individual and institutional levels will complete the program. Further information may be obtained by contacting the AMA Department of Hospitals and Health Facilities, (312) 751-6654.

**SMOKING AND HEALTH PROGRAMS**—The National Interagency Council on Smoking and Health (NICSH) recently completed a survey of 3000 American businesses to determine their activities and attitudes in smoking education programs for employees. They have determined that approximately 15% of U.S. businesses have programs designed to encourage and assist their employees to quit smoking. An additional third of the respondents indicated an interest in developing or expanding such smoking and health programs for their work force. NICSH estimates that cigarette smoking contributes to 350,000 excess deaths each year in the U.S., and a resultant \$5-\$8 billion in direct health care expenses. Further, they find that indirect costs in lost productivity, wages and absenteeism account for another \$12-\$18 billion cost to the American economy. Further information on smoking and health programs in the workplace may be obtained through the National Interagency Council on Smoking and Health, 291 Broadway, Suite 1005, New York, NY 10008.

**FINANCIAL SEMINAR PLANNED**—ISMS and the Illinois CPA Society will co-sponsor a workshop on May 21 for physicians and accountants at the Chicago Pick Congress Hotel. Estate planning, employee benefits, professional incorporation and investment planning will be discussed. Further information about the full-day program may be obtained by contacting the ISMS Division of Medical Services, 55 E. Monroe, Suite 3510, Chicago 60603.

**NEW MEDICAL SCHOOL ENROLLMENT PEAK**—The annual AMA survey of medical school enrollment has found that 1978-79 figures showed an increase of medical students over the previous year. For the second successive year, however, the AMA further found a significant downturn in the number of applicants; this year's drop was almost 4,000 from 1977-78. The AMA report further notes that medical schools graduated a record number of new physicians—14,966—in 1978-79. Some 24.4% of medical students are women, the AMA found, and 12.5% represent ethnic minorities.

**AMA DRUG EVALUATIONS COMPENDIUM**—The newly revised *AMA Drug Evaluations*, a joint effort by the AMA Department of Drugs and American Society for Clinical Pharmacology and Therapeutics, as well as several hundred consultants, is now available. The compendium offers information on indications, alternative drugs, adverse reactions and interactions, etc., of pharmaceutical products. The volume may be ordered by writing Order Department, OP-075, American Medical Association, P.O. Box 821, Monroe WI 53566. The cost is \$48.00.

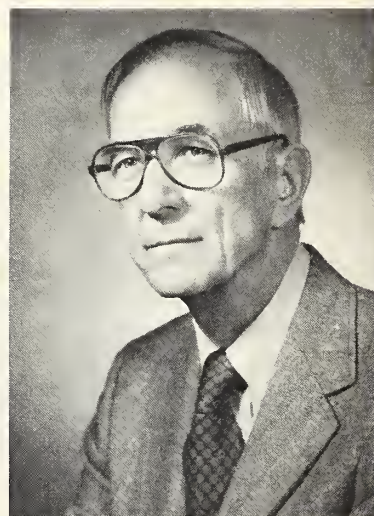
**PSRO SEMINAR ANNOUNCED**—The American College of Utilization Review Physicians, Illinois Chapter, will sponsor a one-day meeting, April 27, 1980, at the Drake Hotel in Oakbrook, Illinois. "Future of PSRO in the 80's," will offer insights to a practice-oriented approach to quality assurance, utilization review and cost containment issues. Category 1 continuing medical education credit will be available to participants. Further information may be obtained by writing Eugene V. Handelman, M.D., chapter president, ACURP National Office, 1108 N. Second St., Harrisburg, PA 17102.

**A REMINDER**—Senate Bill 1355, which became Illinois law as of January 1, 1980, amends the Illinois Controlled Substances Act to (1) include phenmetrazine among the list of designated products; (2) require that "A practitioner who dispenses, other than by administering, a controlled substance in Schedule II, which is a narcotic drug listed in Section 206 of this Act, or which contains any quantity of amphetamine or methamphetamine, their salts, optical isomers or salts of optical isomers, pentazocine, methaqualone, or which is hereafter determined to be a designated product, as defined in Section 102 of this Act, shall do so only upon the issuance of an official prescription blank; and every practitioner who so dispenses such designated products shall comply with the provisions of Sections 310 and 311 of this Act;" and (3) "A practitioner shall not pre-print or cause to be pre-printed a prescription for any controlled substance; nor shall any practitioner issue, fill or cause to be issued or filled, a pre-printed prescription for any controlled substance."

Under this Act, the official triplicate prescription form issued by the Illinois Department of Registration and Education for controlled substances which are "designated products" must be filed with the Department when a controlled substance is *dispensed* from the office.



# President's Page



## An Idea For The 80's: Coalition Politics

The recent AMA National Leadership Conference featured a mixed bag of prophets and pundits who offered their forecasts for the 80's. Predicted was a societal shift from centralization to local control and local leadership. Implied was more regulation at the state level.

Wilbur Cohen, a "voice from the past" who figured prominently in structuring Social Security, called for voluntary state-level action to control health costs. Will wonders never cease?

Several congressmen noted growing bi-partisan support of efforts to check abuse of power by federal agencies. They also stressed that health care should be subjected to marketplace forces, thereby making patients cost conscious and a potent factor in cost containment.

In the past, political party stereotypes have presented a formidable roadblock to cooperative action. A challenge for the 80's is to make *coalition politics* work in a climate characterized by rapid change and an ever-widening range of options.

A handwritten signature in cursive script that reads "Herschel Browns MD".

Herschel Browns, M.D., President

# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603; (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

## MAY

### Acute Care

#### Thyroid Adrenal and Other Endocrine Problems

For: MD's. Dinner/lecture, May 27, 6:00 p.m., Highland Park. Speaker: Sheldon Waldstein, MD. Sponsor: Highland Park Hospital, 718 Glenview Ave., Highland Park 60035. Reg. deadline: 5/17. Fee: \$10. Reg. limit: 60. Credit: Category 1, 1 hour. Contact: Arnold Goldstein, MD. Phone: 312/432-8000 x 4000.

### Cardiology

#### Review of Cardiac Dysrhythmias

For: primary care physicians. Clinical conference, May 14, 2:00 p.m., Innsbruck Lodge, Champaign. Sponsor: Carle Foundation Hospital, 611 W. Park, Urbana 61801. Cosponsors: U of I College of Medicine. Reg. deadline: 5/9. Fee: \$20. Reg. limit: 60. Credit: Category 1, 3 hours; AAFP Elective, 3 hours. Contact: Deborah Rugg. Phone: 217/337-3022.

### Family Medicine

#### The Abnormally Fat and The Abnormally Lean

For: primary care physicians. Course, May 1, Richmond, IN. Sponsor: CME Indiana University School of Medicine, 1100 W. Michigan, Indianapolis, IN 46223. Fee: \$50. Reg. limit: none. Credit: Category 1, 6 hours; AAFP Prescribed, 6 hours. Phone: 317/264-8353.

### Family/Internal Medicine

#### Digestive Diseases—An Update and Review

For: MD's. Symposium, May 9-10, St. Louis, MO. Sponsor: Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis. MO 63110. Fee: \$100. Reg. limit: 150. Credit: Category 1, 8 1/2 hours; AOA, 8 1/2 hours; AAFP Prescribed, 8 1/2 hours. Contact: Loretta Giacoletto. Phone: 314/367-9673.

### Geriatric Medicine

#### Health Care in the Elderly

For: FP's, GP's. Symposium, May 22-23, Iowa City, IA. Sponsor: The University of Iowa Hospitals, Dept. of Internal Medicine, Iowa City, IA 52242. Credit: Category 1, 15 1/2 hours. Contact: Ian Smith, M.D. Phone: 319/356-2727.

### Internal Medicine

#### Midwestern Study Conference

For: GP's, Internists. Lectures/workshops, May 8-10, Chicago City Center-Holiday Inn. Sponsor: Chicago College of Osteopathic Medicine, 5206 S. University, Chicago 60615. Cosponsor: American College of Osteopathic Internists. Reg. deadline: 5/7. Fee: \$150. Reg. limit: none. Credit: AOA, 15-20 hours. Contact: Marie Kowalsky. Phone: 312/947-4606.

### Primary Care

#### EKG Interpretation and Arrhythmia Management

For: GP's, Internists. Lectures/workshops, May 9-10, Chicago. Sponsor: International Medical Education Corporation, 64 Inverness Drive E., Englewood, CO 80112. Reg. deadline: none. Fee: \$245, physicians; \$130, technicians. Reg. limit: 60. Credit: Category 1, 13 hours; AOA, 13 hours; AAFP Prescribed, 13 hours. Contact: Stephen Mattingly. Phone: 800/525-8646 x 237.

## Radiology/Pulmonary

### Chest Radiology: Something Old, Something New

For: primary care physicians. Course, May 7-9, Indianapolis, IN. Sponsor: CME, Indiana University School of Medicine, 1100 W. Michigan, Indianapolis 46223. Fee: \$180. Reg. limit: none. Credit: Category 1, 22 hours; AAFP Prescribed, 22 hours. Phone: 317/264-8353.

## Radiology—Ultrasound

### Third Annual Symposium on Ultrasound;

#### Basic Principles & New Developments

For: Radiologists, Sonographers. Lecture, May 31, Skokie. Sponsor: University of Health Sciences, The Chicago Medical School. Dept. of Radiology, Attn: Dr. W. Hinds, Bldg. 50, Chicago 60664. Reg. deadline: 5/1. Fee: \$60. Reg. limit: 150. Credit: Category 1, 8 hours. Contact: Ben Blivaiss. Phone: 312/942-2965.

## Surgery

### Bariatric Surgery Workshop

For: Surgeons. Workshop, May 29-30, Iowa City, IA. Sponsor: The University of Iowa College of Medicine, Dept. of Surgery, CME, 285 Med Labs, Iowa City, IA 52242. Fee: \$200. Reg. limit: none. Credit: Category 1, 12 1/2 hours. Contact: Magdalen De Bault. Phone: 319/353-5763.

## Surgery

### Endoscopy for Surgeons

For: General Surgeons. Symposium, April 30-May 2, Chicago. Sponsor: Dept. of Surgery, University of Illinois at the Medical Center; Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. Reg. deadline: 4/30. Fee: \$200; \$85, residents. Credit: Category 1, 19 hours. Contact: Lloyd Nyhus, MD. Phone: 312/996-6765.

## PHYSICIANS IMPROVE PERFORMANCE THROUGH CONTINUING EDUCATION

ICCME's first handbook on evaluation of physician learning is now available. It reproduces eight studies from the medical literature that report changes in physician performance as a result of continuing education. An introduction highlights the techniques and procedures used to evaluate learning achievement, suggesting how these might be used by any CME planner.

This handbook is available only to Illinois CME planners. For your free copy, write or call . . .

Illinois Council on CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110 x 158

## JUNE

### Cardiovascular Disease

#### Regression of Atherosclerosis

For: GP's, full-time specialty. Lecture, June 12, 1:30 p.m., Chicago. Sponsor: University of Chicago, Frontiers of Medicine, 1025 E. 57th St., Chicago 60637, Culver Hall 405. Reg. limit: none. Credit: Category 1, 3 hours; AAFP, 3 hours. Contact: Eloine Ehrman. Phone: 312/947-5777.

### Clinical Cardiology

#### Cardiac Pacing Update

For: MD's. Symposium, June 6, 10:45 a.m., Oak Park. Speaker: B. S. Iyer, MD. Sponsor: Oak Park Hospital, 520 S. Maple, Oak Park 60304. Fee: none. Credit: Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

### Clinical Cardiology

#### Refresher Lecture on CPR

For: MD's. Symposium, June 13, 10:45 a.m., Oak Park. Speaker: J. K. O'Donoghue, MD. Sponsor: Oak Park Hospital, 520 S. Maple, Oak Park 60304. Fee: none. Credit: Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

### Clinical Cardiology

#### Emergency Care of Acute M.I.

For: MD's. Symposium, June 20, 10:45 a.m., Oak Park. Speaker: G. G. Lolmalani, MD. Sponsor: Oak Park Hospital, 520 S. Maple, Oak Park 60304. Fee: none. Credit: Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

### Clinical Cardiology

#### Digitalis—It's Use in Chronic Cardiac Failure

For: MD's. Symposium, June 27, 10:45 a.m., Oak Park. Speaker: B. Eshaghy, MD, SC. Sponsor: Oak Park Hospital, 520 S. Maple, Oak Park 60304. Fee: none. Credit: Category 1, 1 hour. Contact: Charles Weigel, MD. Phone: 312/366-7870.

### Family Medicine

#### Family Practice Review—Part II

For: primary care physicians. Course, June 3-5, Indianapolis, IN. Sponsor: CME, Indiana University School of Medicine, 1100 W. Michigan, Indianapolis, IN 46223. Fee: \$165. Reg. limit: none. Credit: Category 1, 16 hours; AAFP Prescribed, 16 hours. Phone: 317/264-8353.

### Family Medicine

#### Specialty Review in Family Practice

For: FP's. Lecture, June 2 (11 days), Chicago. Speaker: Harry Marchmont-Robinson, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood, Chicago 60612. Fee: \$500. Reg. limit: 200. Credit: Category 1, 98 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

### HMO and IPA

#### HMO and IPA—Advantages and Disadvantages

For: MD's. Symposium, June 18, 7:30 p.m., Oak Brook Hyatt House. Speaker: Milton Levine, MD. Sponsor: DuPage County Medical Society, 26 W. St. Charles Rd., Elmhurst 60126. Reg. deadline: 6/16. Reg. limit: none. Credit: Category 1, 2 hours; AAFP Elective, 2 hours. Contact: Lillian Widmer. Phone: 312/495-4050.



## Internal Medicine

### MKSAP V Review Course

For: MD's. Course, June 16-17, Milwaukee, WI. Sponsor: American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. Cosponsors: Medical College of Wisconsin; University of Wisconsin. Fee: ACP member, \$100; non-member, \$150; associate, \$50. Credit: Category 1, 12 hours. Contact: Maxine Topping.

## Internal Medicine/Surgery

### Fluids and Electrolytes

For: Internists, Surgeons. Lecture, June 12 (3 days), Chicago. Speaker: Robert Baker, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood, Chicago 60612. Fee: \$175. Reg. limit: 100. Credit: Category 1, 24 hours. Contact: Robert Baker. Phone: 312/733-2800.

## Laboratory Medicine

### Update on Laboratory Medicine

For: MD's. Symposium, June 18, 8:00 a.m., Waukegan. Speaker: Mayo Foundation. Sponsor: Victory Memorial Hospital, 1324 N. Sheridan Rd., Waukegan, IL 60085. Fee: \$5. Reg. deadline: none. Reg. limit: 120. Credit: Category 1, 5 hours; AAFP Elective, 5 hours. Contact: S. Veiga, MD. Phone: 312/688-4253.

## Medicine

### Legal Aspects of Medicine

For: MD's. Symposium, June 4, 6:00 p.m., Alton. Sponsor: SIU School of Medicine, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Recent Developments in Compatibility Testing

For: MD's. Course, June 19, Quad Cities. Speaker: Bruce Friedman, MD. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust St., Davenport, IA 52803. Fee: \$15. Credit: Category 1; AOA; AAFP. Contact: Patricia Harrod. Phone: 319/359-5401.

## Medicine

### Cardiac Emergencies

For: MD's. Symposium, June 19, 1:00 p.m., Litchfield. Sponsor: SIU School of Medicine, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Medicine

### Medical/Legal

For: MD's. Symposium, June 26, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, Box 3926, Springfield 62708. Reg. limit: none. Fee: \$30. Credit: Category 1, 4 hours; AAFP Prescribed, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## Neurosurgical Intensive Care

### Neurosurgical Intensive Care Symposium

For: MD's, RN's. Symposium, June 11-12, Inn on the Park, Madison, WI. Sponsor: University of Wisconsin-Extension, 465B WARE Bldg., 610 Walnut St., Madison, WI 53706. Cosponsors: University of WI-Madison, School of Medicine, Division of Neurological Surgery. Fee: \$110, MD; \$60, nurse. Reg. limit: none. Credit: Category 1, 17 hours; Univ. of WI, 1.7 CEU's. Contact: Sarah Aslakson. Phone: 608/263-2856.

## Pediatrics

### Comprehensive Care for Cleft Palate Children

For: Pediatricians. Symposium, June 7, St. Louis, MO. Sponsor: Office of CME, Washington University School of Medicine, Box B063, 660 S. Euclid St., St. Louis, MO 63110. Fee: \$75. Reg. limit: 150. Credit: Category 1, 6 hours. Contact: Loretta Giacoletto. Phone: 314/367-9673.

## Radiology

# JULY

## Pediatrics

### Specialty Review in Pediatrics

For: Pediatricians. Lecture, July 15 (6 days), Chicago. Speaker: Ira DuBrow, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$300. Reg. limit: 200. Credit: Category 1, 59 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Surgery/Trauma

### Changing Concepts in Trauma Care

For: MD's, RN's. Symposium, June 7, Marriott Lincolnshire Resort, Lincolnshire. Sponsors: University of Health Sciences/The Chicago Medical School; St. Mary of Nazareth Hospital, 2233 W. Division St., Chicago 60622. Reg. deadline: 5/17. Fee: \$100, MD; \$50, others. Reg. limit: 200. Credit: Category 1, 8 hours. Contact: Krishnan Sriram, MD. Phone: 312/770-2243.

## Surgery

### Changing Concepts in Trauma Care

For: Surgeons, FP's, Emergency Room Physicians. Lecture, June 7, 8:00 a.m., Lincolnshire. Cosponsors: University of Health Sciences, The Chicago Medical School; St. Mary of Nazareth Hospital, 2233 W. Division, Rm. 1043, Attn: Dr. Sriram, Chicago 60622. Reg. deadline: 5/10. Fee: \$100. Reg. limit: 200. Credit: Category 1, 8 hours. Contact: Ben Blivaiss. Phone: 312/942-2965.

## Surgery

### Current Surgical Concepts

For: Surgeons, GP's, FP's. Symposium, June 19-20, Chicago. Sponsor: Dept. of Surgery, The Medical School, Northwestern University, c/o Alumni Center for Continuing Education, 301 E. Chicago Ave., Chicago 60611. Fee: \$150. Reg. limit: 250. Credit: Category 1, 13 hours. Contact: Lori Dorfner. Phone: 312/649-8533.

## Surgery/Oncology

### Current Concepts in Management of

#### Common Neoplasms

For: Surgeons, Oncologists. Lecture, June 9 (3 days), Chicago. Speaker: Tapas Das Gupta, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood, Chicago 60612. Fee: \$175. Reg. limit: 75. Credit: Category 1, 24 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Urology

### Clinical Problems in Urology

For: Radiologists. Symposium, June 6-7, Chicago. Sponsor: Dept. of Urology, The Medical School, Northwestern University, c/o ACCE, 301 E. Chicago Ave., Chicago 60611. Fee: \$175. Reg. limit: 200. Credit: Category 1, 15 hours. Contact: Lori Dorfner. Phone: 312/649-8533.

## SECOND INTERNATIONAL SYMPOSIUM THORACIC OUTLET SYNDROME AND NERVE ENTRAPMENTS

Guadalajara, Mexico  
March 6, 1981

Sponsors: American College of Surgeons, Mexican Chapters; Little Company of Mary Hospital, 2800 W. 95th St., Evergreen Park 60647. Attn: Nestor Martinez, MD. Reg. deadline: ASAP. Fee: \$150. Reg. limit: 100. Credit: Category 1, 8 hours. Contact: Lois Arnold. Phone: 312/445-6000 x 5043.

## Primary Care

### EKG Interpretation and Arrhythmia Management

For: GP's, Internists. Lectures/workshops, July 25-26, Mackinac Island, MI. Sponsor: International Medical Education Corporation, 64 Inverness Drive E., Englewood, CO 80112. Reg. deadline: none. Fee: \$245, physician; \$130, technician. Reg. limit: 60. Credit: Category 1, 13 hours; AOA, 13 hours; AAFP Prescribed, 13 hours. Contact: Stephen Mattingly. Phone: 800/525-B646 x 237.

## Psychiatry

### Geriatric Psychiatry

For: Psychiatrists. Lecture, July 31 (2 days), Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$175. Reg. limit: 100. Credit: Category 1, 16 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## Quality Assurance

### Seminar on Quality Assurance

For: MD's, administrators. Workshop, July 10-11, Chicago. Sponsor: Illinois League for Nursing, 205 W. Wacker Dr., Chicago 60606, attn: Denise McCleverty. Reg. deadline: none. Fee: none. Reg. limit: 150. Credit: Category 1, 11 hours. Contact: Felix Liddell. Phone: 312/642-6061.

## Radiology

### Radiation Safety in Diagnostic Radiology

For: Radiologists. Lecture, July 24 (3 days), Chicago. Speaker: Theodore Fields, MS. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$250. Reg. limit: 75. Credit: Category 1, 24 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

## RECENT CME ACCREDITATIONS

The ISMS Committee on CME Accreditation has approved the CME programs of the following institutions:

North Shore Mental Health  
Association—Irene Josselyn  
Clinic, Northfield  
St. Joseph Hospital, Elgin

## CME CATALOG NOW AVAILABLE

All physicians will be interested in the "AMA Continuing Medical Education Catalog for 1980." This informative catalog lists about 200 national courses, workshops, scientific meetings and various other activities covering a wide range of specialty topics. Most programs are designated as Category 1. To obtain your free copy, write: AMA, Division of Continuing Medical Studies, 535 N. Dearborn St., Chicago, IL 60610, or call, 312/751-6570.

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** Wanted—American-trained family physician to join established family physician in active practice. Guaranteed salary and excellent benefits. Eventual partnership. Robert N. Arrol, M.D., 126 South Locust, Arcola 61910 or 217-268-4444 or 217-268-4404. (4)

**ATKINSON:** A modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond-Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles to Peoria (UI). All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235 (309-936-7566). (7)

**BLOOMINGTON:** Physician to work in anesthesia mornings, general practice afternoons. Space available in clinic with pediatric group of 4 doctors. Attached ambulatory surgical facility. Central Illinois community, area population over 100,000. 135 miles from Chicago, near Universities and Colleges. For further information contact: Dr. H. R. Hadden, 2708 Mc Graw Dr., Bloomington 61701 (309-633-2306). (8)

**CHICAGO AREA SUBURBS:** Western Cook, DuPage Counties, including Oak Brook, Downers Grove, Wheaton, Lombard, LaGrange, Palos Hills. Opening in new and established multi-specialty medical groups. Complete office facilities with nearby hospital affiliations. Various practice and financial arrangement available. General Practice, Internal Medicine, Family Practice, Obstetrics & Gynecology, Otolaryngology, and Orthopedic Surgery. CONTACT: Jim Gott, Administrator, Suite 205, 6800 S. Main Street, Downers Grove, 60515, 312-852-9400. (12)

**DAVENPORT, IA:** Ten man group with two OB-GYN's seeks another OB-GYN partner. Attractive offer now with promising future. Send C.V. We will call. Gordon Rock, M.D., The Davenport Clinic, 1820 West Third Street, Davenport, Iowa 52802. (7)

**DEKALB:** Northern Illinois University, a state university of approximately 22,000 enrollment, needs a sports medicine/emergency room physician to serve as university team and trauma room physician. Qualifications: Illinois license to practice medicine and surgery and pertinent experience in sports medicine and trauma care. Salary competitive; good fringe benefits. Ten or twelve months per year. To start July 1 or August 1, 1980. Contact: Loren W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, 60115. Northern Illinois University is an Equal Opportunity/Affirmative Action employer. (7)

**EL PASO:** Family practitioner for rewarding primary care and family physician. Fully equipped office in excellent location. Primarily farming community in North Central Illinois. Fifteen miles from hospitals in Normal-

Bloomington with cultural advantages of two universities—Illinois Wesleyan, and Illinois State University. Ten miles from Eureka Hospital and 35 miles to Peoria with U of Ill Medical School and Bradley University. Financing available. A warm, personal community that would welcome a needed physician. CONTACT: Kearney Clinic, 3 Grant Street, El Paso 61738 (309-527-5752). (7)

**FAIRBURY:** Primary Care and Family Practice Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (12)

**FREEPORT:** Urologist, Ob-Gyn, and General Surgeon, Board Certified or Eligible, to join multi-specialty group in community of 35,000 in Northern Illinois. Salary negotiable first year, then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, Illinois 61032. (815-235-6131) (7)

**FREEPORT:** Orthopedic Surgeon—Pediatrician—Otolaryngologist—Needed to join 20 physician, multi-specialty clinic. New facilities, fully equipped, adjacent to hospital. Attractive financial arrangement with many fringe benefits. No investment. Contact J. S. Schoenberger, Business Manager, Freeport Clinic, S. C., 1036 West Stephenson Street, Freeport, 61032, AC 815/235-5111. (12)

**FRANKFORT:** Pediatrician wanted for 10 man multi-specialty group, thirty miles southwest of Chicago. Profit sharing, new building and excellent practice opportunity. Contact: Howard Osmus, Administrator, Hedges Clinic, Frankfort 60423 (815-469-2123). (8)

**GENOA:** Population 3500 (surrounding area 15,000). Excellent professional and cultural opportunity for physician seeking independent family practice. Pleasant family community. Located between Chicago, DeKalb, and Rockford. 15 miles from Northern Illinois University. Contact: Irving M. Bush, M.D., 1 Chapman Road, Burlington, 60109. Phone 312-683-2066 or 312-683-2081. (4)

**HINSDALE:** Western suburbs of Chicago. Wholistic Health Center of Hinsdale. Facilities already established in the Union Church. Prefer certification or experience in Family Practice. Must be committed to working with team. Salary and contract negotiable. Contact Dr. John Payne, 137 S. Garfield, Hinsdale, Il., 60521. (7)

**ILLINOIS:** Modern JCAH Mental Health Center seeks a child psychiatrist, psychiatrist and physician. All require Illinois Medical License. Psychiatry positions re-



quire Board Certified/Eligible status. Rich environment. Salary commensurate with experience, plus on-call pay. CONTACT: T.R. Adams, 502 Stratton Bldg., Springfield, 62706, or phone (217) 782-4795. (4)

**MT. VERNON:** Board Certified or Eligible OB-GYN to join 36 year old established same in rapidly growing town of 20,000 with good schools, nice people, lots of recreational opportunities and easy access to St. Louis. Modern 200 bed JCAH hospital; new office in the works. Good initial salary and benefits and early partnership. CONTACT: Tom Weinberg, M.D., PO BOX 1604, Mt. Vernon 62864 (618-244-2235). (8)

**OBLONG:** Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

**PALMYRA:** Population 800, three more villages in our school District. No doctor at present. New doctor's office equipped free of charge, utilities furnished. Hospital less than an hour drive, ambulance service, recreational facilities, and nearby airport. CONTACT: Oral Cooper, Village of Palmyra, Palmyra, 62674 (217-436-2521). (8)

**ROCKFORD:** Full-time emergency department physician needed to join fee-for-service group. 35,000 annual visits. 420 bed hospital, 85 miles west of Chicago. Send C.V. or contact Robert C. Porter, M.D., Director, Emergency Department, Swedish American Hospital, 1400 Charles Street, Rockford 61101 (815) 968-4400, Ext. 4105. (4)

## FIVE WEDNESDAYS IN FAMILY PRACTICE

### The Fifth Annual Family Practice Review Course

**May 7, 14, 21, 28, June 4, 1980**

**Department of Family Practice  
Rush-Presbyterian-St. Luke's  
Medical Center  
Chicago, Illinois**

Important aspects of clinical medicine to be reviewed include cardiology, oncology, alcoholism, low birth weight infants, and chronic disease in the elderly patient. Special emphasis will be directed to aspects of health promotion and disease promotion. This course is acceptable for up to 36 hrs. of prescribed credit by AAFP and AMA Category I.

*For more information contact Patricia Wilson, Rush-Presbyterian-St. Luke's Medical Center, University Office of Continuing Education, 600 So. Paulina, Chicago, IL. 60612 (312) 942-7095.*

## On the Cover

# The General Assembly is Back in Session

Pictured is the state capitol, which reminds us that the Spring Session of the Illinois General Assembly began March 26. While technically limited to review of budgetary and fiscal matters, many other pending bills of interest to the medical profession may be considered.

Over the years, it has become increasingly important that ISMS monitor ever-widening categories of bills. As efforts are made to broaden regulatory activities affecting the practice of medicine, many attempt to legislate regulatory matters or to broaden the scope of activity without a corresponding increase in qualifying criteria.

In this context, it is vitally important that all physicians become aware of activities in Springfield and become personally involved in legislative matters. ISMS, and its Governmental Affairs

Division, can help through ISMS' legislative newsletter, "On the Legislative Scene," (OLS) which provides up to the minute status reports on important bills. Anyone who wishes to be added to the OLS mailing list should contact the Governmental Affairs Division, ISMS, 55 E. Monroe, Suite 3510, Chicago IL 60603; (312) 782-1654.

Without your participation, medicine is weakened in addressing the issues. Physicians are encouraged to get involved, to impact on the system. Let your voice be heard. Read OLS—get to know your legislators personally—watch issues under consideration in the legislature—share your views on the issues with your representatives—and let ISMS know of your position on legislative matters which impact on you and your practice.

## “I Quit” Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of “I Quit Smoking” clinics around the state. The clinics are held for five days in 1½ hour sessions. The Hinsdale clinics listed below require a registration fee of \$10.00, but the remaining sessions are offered at no cost to participants.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

April 21	Riverside Medical Center & A.C.S.	Kankakee	April 29	Victory Memorial Hospital & A.C.S.	Waukegan
April 21	Homewood Flossmoor Park Dist. & A.C.S.	Homewood	April 29	Lutheran General Hospital	Park Ridge
			May 6	Daley Center	Chicago
			May 11	Hinsdale Sanitarium & Hospital	Hinsdale
			June 3	Daley Center	Chicago
			June 8	Hinsdale Sanitarium & Hospital	Hinsdale
			June 23	Christ Hospital & A.C.S.	Oak Lawn
			July 14	Anchor & A.C.S.	Chicago
			July 29	Lutheran General Hospital	Park Ridge
			September 15	Christ Hospital	Oak Lawn
			October 6	Lake Forest Hospital & A.C.S.	Lake Forest
			October 13	Blessing Hospital & A.C.S.	Quincy
			October 28	Lutheran General Hospital	Park Ridge
			November 17	Christ Hospital	Oak Lawn
			December 1	Anchor & A.C.S.	Chicago

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# Illinois Housestaff News

## What Role is the Federal Government to Play?

### Privacy of Medical Records

BY LINDA HUGHEY HOLT, M.D., SECRETARY/EDITOR

Several recent pieces of proposed federal legislation attempt to define the areas of legal access to medical records. As future practitioners, current residents should be informed of the content of proposed legislation, as the proposals before the House and Senate could affect the future practice of medicine and profoundly affect the doctor-patient relationship.

The American Medical Association recently submitted comments on several pieces of proposed legislation to the appropriate Senate and House Committee chairmen. The bills discussed were HR 2929, "Federal Privacy of Medical Records Act," HR 3444 and S 865, both entitled "Privacy of Medical Information Act," and S 503 "Privacy Act Amendments of 1979." The AMA commentary summarizes the changing status of medical confidentiality and some problems with the bills in question.

Historically, medical records confidentiality has traditionally been almost complete. Now, however, (1) computerization of medical records, (2) payment by 3rd party payers and government sources which are increasingly demanding to know diagnosis and treatment before payments are issued, and (3) increasing government intervention in general, combine to form an unprecedented threat to the traditional confidentiality of medical records. The AMA has in fact developed a model state legislative program

which allows for some physician discretion in patient access to records but also makes medical records available to outside sources only with express authorization of the patient.

The federal legislative proposals offer multiple routes of access to medical records without *permission* of the involved patient. For example, HR 2979 allows medical institutions to release identifiable medical information for audit purposes, Secret Service investigations, and judicial authorities following proper legal proceedings. The other bills contain comparable access routes.

While the AMA lauds the congressional concern over medical record confidentiality, the AMA commentary criticizes the proposed legislation as allowing too much access to records, particularly on the part of government agencies. The AMA commentary further suggests that issues of medical record confidentiality should at this time be left to the state lawmakers. State-level legislation would allow for a variety of trial programs in this as yet somewhat young and confusing area of medical record confidentiality in the computer age. Confidentiality of medical records is an extremely important issue for all of us who will be practicing medicine in the years to come. But attempting to establish sweeping federal guidelines at this time seems premature—particularly if those sweeping federal guidelines call for broad government access to private medical records. ◀

\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.



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9-0541M

# Illinois Society, American Association of Medical Assistants

## Bits and Pieces

BY LUELLA V. MITCHELL, CHAIRMAN, PUBLIC RELATIONS

Medical Assistants from throughout the state will convene in Arlington Heights, Illinois (host chapter, McHenry County), April 24-27, 1980 for the 24th annual meeting of the AAMA Illinois Society. The theme of the convention is—"LOVE IS"—EMPATHY—ACHIEVING—LEARNING.

The three day event to be held at the Arlington Park Hilton will be highlighted by the induction of Elaine Kaiser, CMA-A, Oak Forest, as president, who succeeds Cissy A. Egly, CMA, Joliet. Other features of the convention include the election and installation of officers.

Subjects to be covered during the educational sessions will include "Love Is—Meeting the Emotional Needs of the Patient, Family, and Medical Assistant," "Forensic Pathology," and "The Legal Problems Affecting the Medical Assistant."

John L. Wright, M.D., Bloomington, Robert R. Hartman, M.D., Jacksonville, Thomas R. Harwood, M.D., Elgin, Leslie Schwartz, M.D., Chicago, J. M. Ingalls, M.D. Paris (ISMS-Liaison), and Allison L. Burdick, Sr., M.D., Chicago (Emeritus member), state medical advisors, will be attending the convention.

Governor Thompson will proclaim the week of April 20-27, 1980 as Medical Assistants Week in Illinois.

### TO BE OR NOT TO BE

The words in the title are small, very short and the longest word has three letters, "not." Many will recall these famous Shakespearean words from the equally famous play, "Hamlet."

What should these words mean to the medical assistant and to members of the Illinois Society? Let us analyze the first two words, TO BE. TO BE, means many things to the Medical Assistant—remember—our association is to help educate the Medical Assistant. TO BE, *does not* and

*should not* command an authoritative outward demand on others. TO BE able to listen attentively, to develop memory, and above all, being careful to answer questions and remarks intelligently and courteously. TO BE able to help, guide, show kindness, and compassion to everyone.

There are so many TO BE's, just thinking about them can expand in developing the character of the Medical Assistant if she sincerely desires it.

NOT TO BE, the longest word here is the word "not." This is an obtuse word to the Medical Assistant. NOT TO BE can be used in ways not becoming to the Medical Assistant. NOT TO BE a part of a professional, educational association, NOT wanting continued education, NOT wanting to participate with other members in the same profession. NOT TO BE able to find friendships and exchange ideas, are only a few of the NOT TO BE's to the Medical Assistant whose only diversion in life is her work. The mind needs to continue to learn, to grow, to expand at all times. The NOT TO BE, must be left behind. The TO BE has to be pressed forward. WHICH IS YOUR MEDICAL ASSISTANT. DEAR DOCTOR, THE "TO BE" or the "NOT TO BE?"

### TO ISMS MEMBERS

The Illinois Society will have information available at your coming meeting. Please stop at our display, ask questions, pick up literature, or just introduce yourself. We'll be looking forward to seeing you.

For information regarding AAMA Illinois Society, contact Cissy A. Egly, CMA, President, 1413 Midland Manor, Joliet, IL 60436, or Luella V. Mitchell, Chairman, Public Relations Committee, 7920 Eberhart Avenue, Chicago, IL 60619.



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# REPORT

## FOR *Illinois Physicians*

### Service Improvement Program Underway

There's something new at the Chicago-based Blue Cross and Blue Shield Plan and all indications are that it will have a great impact on service improvement efforts.

After several years of planning and testing, the Plan has started evolving from a functional to a full service concept in its claims administration procedures. The result will be prompt, accurate and personalized service to meet the needs of members.

It's not as if members have not been receiving proper service. It's just that it was time for the functional type organization, which had worked so well in the past, to change into something new.

In the 1960s, when computer systems were developed for widespread use in business, the idea of putting similar kinds of functions together made a great deal of sense. Hospital and medical/surgical benefits were similar for all subscribers, so why not put all hospital claims together in one area, all medical/surgical claims together in another area.

Today, with contracts so complex and varied to meet certain needs, it's important for claims handlers to become familiar with all the benefits of the specific contracts. And the way to do this is to change from an organization where people have to know all the different hospital benefits for all subscribers to one where people know about the total benefit package for several groups.

Currently, 14 units have been established as a result of the full service goal, and another five are scheduled to go up by mid-Summer. It may appear that these units are established overnight, or over a week end. However, it is important to realize that much planning and thought go into the creation of each new unit.

While the creation of each Full Service Unit requires much decision-making, actual implementation falls into a pattern.

The first areas to come into a new unit are Blue Shield and Major Medical. The areas that

follow are, in order, Group Inquiries, Blue Cross, Membership and Subscriber Inquiries.

With Blue Cross, Blue Shield, Major Medical, Inquiries and Membership all within each Full Service Unit, does anything remain as a functional unit? Yes. A certain few departments will work better on a functional basis while still providing Full Service to customers.

Full Service for telephone callers will continue to begin in the Central Telephone Communication (CTC) area.

Despite the fact that some FSC Units (State of Illinois, Comprehensive Major Medical and FEP) have their own Coordination of Benefits areas, COB will remain a separate unit at present. While this situation could change in the distant future, the Full Service Units must maintain a continuing relationship with COB to make sure that subscriber's additional coverage is identified in order to maximize the COB savings and recoveries achieved for each of our accounts.

ADS/Drugs/Dental—each function involves its own process, system and unique relationship with both subscribers and providers and therefore each will remain together in one separate functional unit.

Naturally, with a transition of this magnitude from functional to full service units, problems do arise.

"Nothing we can't handle," vice president Fran O'Connell said, "but the little things you don't think about are what cause most of the headaches."

"Our training needs have also increased," added director Art King. "We're in the process of changing people's attitudes so they can effectively participate in the Full Service Concept. We're not people who manage paper, but people who provide service.

"And we're people who are working together as a team to accomplish our goal. It takes a while to understand the difference of who we were before and who we have become," King said.

## In Hospital Medical Care

Benefits are provided under most Blue Shield Certificates for medical care rendered when the patient is hospitalized. Allowances vary in accordance with the type of Blue Shield Certificate held by the member.

Admission date, discharge date, diagnosis and the number of in-hospital daily visits made be reported before claims can be paid properly.

To avoid returning reports for additional information which delays payment, it is essential that the questions on Blue Shield's Physician's Service Report. "Was surgery also performed?" be answered, and "If so, by whom?", even if all services performed were medical (nonsurgical).

Medical care rendered concurrently with surgical or obstetrical care during a period of hospitalization is not usually a covered benefit. However, in unusual instances, if the medical care is essential to and distinct from the usual pre-operative and post-operative care, a detailed report from the physician rendering medical care, describing in full the nature of his services, should be submitted for consideration.

When two or more physicians render "active and continuous" medical care during a period of hospitalization, each physician submitting a report to Blue Shield should name the other physicians associated on the case.

## Intensive Medical Care

Certain Blue Shield Certificates provide allowances for Intensive Medical Care. This is defined in our Certificates as "services of an extraordinary degree involving an excessive effort as reported by the attending physician."

Some conditions in which the physician may be required to render such service include acute myocardial infarction, massive gastrointestinal hemorrhage, diabetic ketosis with coma, acute congestive heart failure, acute encephalitis, acute or chronic nephritis with uremia, acute nephrosis, Addison's disease of the adrenals with acute crisis, massive pulmonary hemorrhage, acute laryngotracheal bronchitis of infants and children.

Therefore, when such care is given, the nature of the care should be fully described when completing the Physician's Service Report.

(Please Note: The following information regarding the Medical Necessity project contained in the April issue of Report for Illinois Physicians was mislabeled "Procedures Payable When Performed For The Specific Conditions Indicated." The correct heading is "Procedures Requiring Justification When Performed for the Specific Conditions Indicated.")

## Procedures Requiring Justification When Performed For The Specific Conditions Indicated

PROCEDURE DESCRIPTION	CONDITIONS
Excision of carotid body tumor without excision of carotid artery (1)	asthma
Extra-intra cranial arterial bypass (1)	complete stroke
	Carotid artery obstructive disease not amenable to endarterectomy, symptomatic
	Middle cerebral artery obstructive disease, symptomatic
	Vascular or neoplastic lesions risking occlusion of major cerebral artery during operative correction
Fascia lata by incision and area exposure, with removal of sheet (1)	lower back pain
Fascia lata by stripper (1)	lower back pain
Ligation of femoral vein, bilateral (1)	post-phlebitic syndrome
Ligation of femoral vein, unilateral (1)	post-phlebitic syndrome
Sympathectomy, lumbar, bilateral (1)	hypertension
Sympathectomy, lumbar, unilateral (1)	hypertension
Sympathectomy, thoracolumbar, bilateral (1)	hypertension
Sympathectomy, thoracolumbar, unilateral (1)	hypertension
Splanchnicectomy, bilateral (1)	hypertension
Splanchnicectomy, unilateral (1)	hypertension

(This report is a service to the physicians of Illinois)





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## Surgical Progress

During the past two decades, thoracic and cardiovascular surgical techniques, operative experience and patient survival have shown steady and rapid improvement. Thoracic aortic lesions, until a few years ago, were either non-correctable or correctable with a prohibitively high morbidity and mortality rate—particularly in the non-emergent situation. However, non-intervention leads to a high incidence of complications and near 100% mortality in thoracic aortic aneurysm rupture or traumatic aortic disruption. Continued enlargement by the true or false aortic aneurysm may lead to hoarseness, aortic valvular insufficiency, aortotracheal or aortoesophageal fistula, pericardial tamponade, rupture into the free pleural space, Horner's syndrome or caval obstruction.

Because of the high risk of death with these lesions, surgeons have continued to approach the problem in an attempt to salvage those individuals so involved. The result has been continued improvement in the survival of these patients through the use of angiography, surgical technique, cardiopulmonary bypass, modern graft materials and clinical awareness. This month's article by Dr. Meng, *et. al.*, demonstrates the significant decrease in operative mortality to 15% in their series, including ascending, arch and descending aneurysm formation. Further, since 1974, their mortality has been diminished to 6.5%—a truly remarkable and highly acceptable rate for such a lethal lesion. Similar improvements in the salvage rates are beginning to be demonstrated in the community hospital.<sup>1</sup> This fact should alert physicians to the need for evaluation and possible surgical repair in such a patient.

Raymond A. Dieter, M.D.  
Member, *IMJ* Editorial Board

### References

1. Dieter, R.A., Asselmeier, G.H., Hamouda, F., Kuzycz, G.B., and McCray, R.M.: "Traumatic Disruption of the Aorta," Presented International College of Surgeons Meeting, May 13-17, 1979, Paris, France.

*in recurrent urinary tract infections*





# Bactrim attacks susceptible uropathogens from site to source

Uropathogens originating in the lower intestine have been shown to colonize the vaginal introitus.<sup>1</sup> From this staging area, they enter the urinary tract, where they cause recurring infections in susceptible women.

Bactrim, highly effective against the most common uropathogens, fights infection at three important points: 1) at the site of infection, 2) in the vaginal introitus and 3) at the original source, the colon.

And Bactrim goes beyond other antimicrobials in its dual action. Each component blocks bacterial folic acid metabolism at a different point in the biosynthetic pathway, minimizing the development of resistant strains.<sup>2</sup>

Bactrim is contraindicated during pregnancy and the nursing period, in patients hypersensitive to its components, and in infants under 2 months. During therapy, maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

References: 1. Brumfitt W, et al: *Br Med J* 2:1471-1472, Dec 18, 1976. 2. Gale EF, et al: *The Molecular Basis of Antibiotic Action*. New York, John Wiley & Sons, 1972, p. 36.

ONE TABLET  
B.I.D. FOR  
10 TO 14 DAYS

# BACTRIM™ DS

(400 mg trimethoprim and 800 mg sulfamethoxazole)

\*See indications in summary of product information.

NEW

ROCHE LABORATORIES  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

**Indications and Usage:** For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

**Note:** The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

**For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae*** when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age. For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

**For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei*** when antibacterial therapy is indicated.

**Also for the treatment of documented *Pneumocystis carinii* pneumonia.** To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings:** **BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A  $\beta$ -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:**

Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

**Dosage:** Not recommended for infants less than two months of age. **URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:**

**Adults:** Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

**Children:** Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

**For patients with renal impairment:** Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if clearance is below 15 ml/min.

**ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:**

**Usual adult dosage:** 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

**PNEUMOCYSTIS CARINII PNEUMONITIS:**

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

**Supplied:** Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28 tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. **Pediatric Suspension,** containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; cherry flavored—bottles of 16 oz (1 pint). **Suspension,** containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored—bottles of 16 oz (1 pint).



## Clinics for Crippled Children Listed for June

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 23 general clinics, 10 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- June 3 Maryville—Oliver C. Anderson Hospital
- June 3 Park Ridge Cardiac (a.m.)—Lutheran General Hospital
- June 3 Park Ridge General (p.m.)—Lutheran General Hospital
- June 3 Wheaton General—Marianjoy Rehab. Hosp.
- June 4 Hinsdale—Hinsdale Sanitarium
- June 4 Springfield Ped-Neuro—St. John's Hospital
- June 4 Carmi—Carmi Township Hospital
- June 5 Lake County Cardiac—Victory Memorial Hospital
- June 5 Sterling—Community General Hospital
- June 6 Division Cardiac—U. of I. at the Medical Center
- June 9 Peoria Cardiac—St. Francis Hospital
- June 9 Chicago Heights Cardiac—St. James Hosp.
- June 10 East St. Louis—Community Hospital
- June 11 West Frankfort—UMWA Union Hospital
- June 11 Champaign-Urbana—McKinley Hospital
- June 11 Joliet—St. Joseph's Hospital
- June 11 Elgin MM—Sherman Hospital
- June 12 Aurora Cardiac—Mercy Center for Health Care Services
- June 12 Kankakee General—St. Mary's Hospital
- June 12 Rockford—St. Anthony Hospital
- June 12 Springfield General—St. John's Hospital
- June 17 Maywood—Loyola Medical Center
- June 17 Belleville—St. Elizabeth's Hospital
- June 17 Rock Island Area General—Moline Public Hospital
- June 17 Decatur—Decatur Memorial Hospital
- June 18 Chicago Heights General—St. James Hosp.
- June 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
- June 19 Bloomington—Mennonite Hospital
- June 20 Kankakee Cardiac—St. Mary's Hospital
- June 23 Peoria Cardiac—St. Francis Hospital
- June 23 Chicago Heights Cardiac—St. James Hosp.
- June 24 Peoria General—St. Francis Hospital
- June 25 Aurora General—Mercy Center for Health Care Services
- June 27 Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

- provides effective symptomatic relief
- b.i.d. dosage simplifies therapy
- scored tablet for dosage flexibility

### OPTIMINE®

azatadine maleate, 1 mg. tablets

**CONTRAINDICATIONS** Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and premature infants in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

**WARNINGS** Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer; pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined:

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

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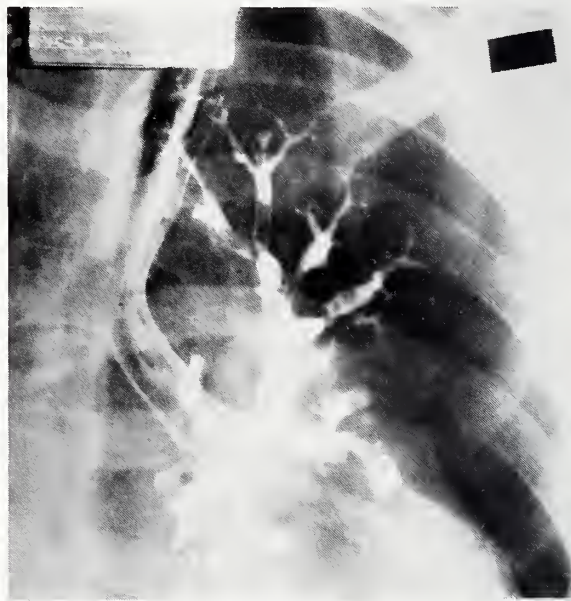
# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This 24-year-old woman has dyspnea on exertion. The volume of the left lung doesn't change with inspiration-expiration chest radiographs indicating air trapping. There is decreased blood flow to the left lung on perfusion lung scanning.*



**Figure 1**  
PA Chest



**Figure 2**  
Bronchogram, Left Lung

## *What's your diagnosis?*

1. Congenital Hypoplastic Left Pulmonary Artery
2. Pulmonary Embolism
3. Neoplasm Compressing Left Pulmonary Artery
4. Swyer-James' Syndrome (Unilateral Hyperlucent Lung)
5. Endobronchial Lesion, Left Main Bronchus

*(Continued on page 316)*



# for "cardiac separation"...



Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

You can help minimize "cardiac separation" with a program of

counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).

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#### **CARDILATE® (ERYTHRITYL TETRANITRATE)**

**INDICATIONS:** Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

**CONTRAINDICATIONS:** Idiosyncrasy to this drug

**WARNING:** Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

**PRECAUTIONS:** Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

**ADVERSE REACTIONS:** Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspira-

tion and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

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Reference: 1. Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987-1970.

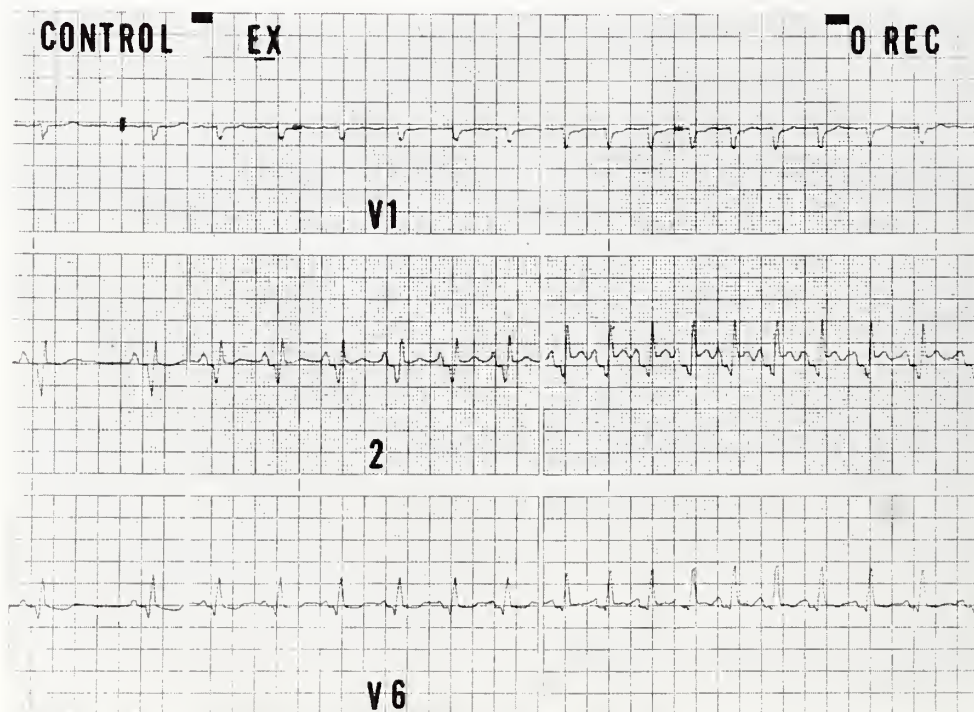
**Burroughs Wellcome Co.,**  
Research Triangle Park, North Carolina 27709



# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Sconlon, M.D., Sarah A. Johnson, M.D., John R. Tabin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a forty-seven year old executive who first developed angina pectoris in 1969. In 1971, he had a coronary angiogram and then aortocoronary bypass surgery. He did reasonably well until 1978, when he had an uncomplicated myocardial infarction. His hypercholesterolemia had been corrected and he had stopped smoking cigarettes. In 1979, he again developed angina pectoris. It was relatively mild and did not prevent him from carrying out normal activity. He wanted to start an exercise program and presented for evaluation although he had had no angina at all in the previous three months. An exercise test with a Thallium myocardial perfusion scan at rest and immediately after exercise was performed. Selected leads V<sub>1</sub>, 2, and V<sub>6</sub> recorded simultaneously from the ECG are shown for the control period, early exercise, and at zero recovery or the end of exercise.*



## Questions:

### 1. The ECG shows:

- A. A short run of ventricular tachycardia.
- B. Exercise induced left bundle branch block.
- C. Marked ST segment depression.
- D. Marked ST segment elevation.
- E. An increase in the R wave amplitude.

### 2. These exercise ECG findings are frequently found in the presence of:

- A. Significant coronary artery disease.
- B. Abnormal left ventricular function with or without an aneurysm.
- C. Variant angina (Prinzmetal).
- D. All of the above.

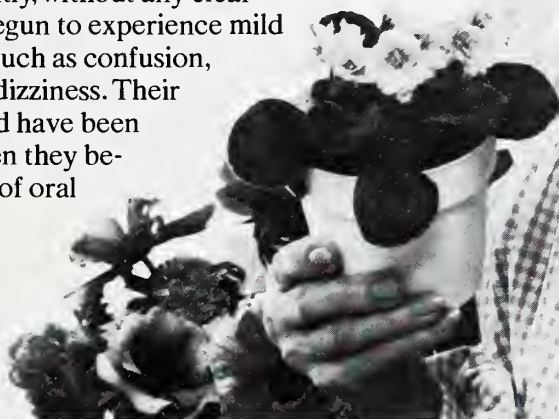
(Continued on page 314)



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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



## The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—their ability to function can be maintained.

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**Precautions:** Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

**Adverse Reactions:** Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

**Dosage and Administration:** 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

**How Supplied:** Hydergine tablets (for oral use) 1 mg, packages of 100 and 500.

**Hydergine sublingual tablets 1 mg**, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg, packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg**, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg, packages of 100 and 1000.

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# Physician Registration

## With County Clerk Required

Under current Illinois law, the Domestic Relations Act (Chapter 40, Section 204—Part II, Marriages) requires that physicians completing a premarital physical complete a form to be filed with the County Clerk. The form reads as follows:

I, (Name of Physician . . . .) being a physician, legally licensed to practice in the State of . . . . . (by credentials being filed in the office of . . . . .) do certify that I did on the . . . . . day of . . . . . 19. . . . make an examination of . . . . . and considered the result of an approved serological test for syphilis, which was made at my request, and believe . . . . . to be free from all venereal diseases.

.....  
Signature of Physician

.....  
Signature of Person Examined

This indicates that a physician must register his credentials (his license) with the appropriate county clerk if the certificate is to be valid.

Further, the Medical Practice Act provides that each county clerk is to receive annually a listing of physicians currently licensed in Illinois to use in validation of credentials of physicians signing vital records.

This is called to attention for the information of those who may not have registered with their county clerk and may wish to do so. In addition, physicians must renew their license prior to July 1, 1980. Non-renewal would remove the name from the list of current licenses. If you have not received a renewal notice, please contact the Medical Licensure Section, Department of Registration and Education, 320 W. Washington Street, Springfield, Illinois 62786. ◀

## Brief Summary

**INDICATIONS** — Symptomatic relief of anxiety and tension associated with anxiety disorders, other psychoneurotic disorders, transient situational disturbances, and functional or organic disorders. Symptomatic relief of acute alcohol withdrawal.

Effectiveness in long-term use (over 4 months) not assessed by systematic clinical studies. Physician should periodically reassess usefulness for each patient.

**CONTRAINDICATIONS** — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

**WARNINGS** — Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 18. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**PRECAUTIONS** — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**ADVERSE REACTIONS** — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

**DOSAGE** — ANXIETY—Usual daily dose 30 mg or less (start the elderly or debilitated at 7.5-15 mg). Adjust gradually within 15-60 mg daily range. Capsules and scored tablets: divided doses; or once daily h.s. (start patient at 15 mg). Single Dose Tablets, 22.5 mg (for patients stabilized on 7.5 mg t.i.d.) or 11.25 mg: once daily at any hour. ALCOHOL WITHDRAWAL—In divided doses: 1st day 30 mg initially, then 30-60 mg; 2nd day 45-90 mg; 3rd day 22.5-45 mg; 4th day 15-30 mg. Then taper to 15-7.5 mg daily, and discontinue as soon as stable.

**INTERACTIONS** — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants.

**OVERDOSAGE** — Take general measures as for any CNS depressant.

**SUPPLIED** — Tranxene (clorazepate dipotassium) 3.75, 7.5, and 15 mg capsules and scored tablets. Tranxene-SD Half Strength 11.25 and Tranxene-SD 22.5 mg single dose tablets.

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# Illinois Housestaff News

## Cost Containment Commentary

BY LINDA HUGHEY HOLT, M.D., RPS SECRETARY/EDITOR

Since physicians are alleged to generate some 70% of health care costs,<sup>1</sup> a great deal of attention has focused on physician utilization of diagnostic tests and the resulting costs. Experiences of residents at Rochester, N.Y., Charlotte, N.C., and in the US Public Health Service provide some interesting light on the subject of cost containment.

### The Rochester Experience

Starting with hypotheses—that training level would correlate with knowledge of test applicability and that at higher levels of training physicians would show greater selectivity for screening tests (hence reducing costs)—a series of Medical Residents and Attendings at Rochester, New York were surveyed. They indicated which screening tests they routinely ordered and were given a questionnaire to ascertain their knowledge of the efficacy of various tests as screening devices. The findings? There was no correlation between level of training and knowledge of test characteristics. Although there was some decrease in routine test-ordering between internship and the third year of residency, both prepaid practice internists and fee-for-service internists ordered more routine tests than did third-year residents.<sup>1</sup> This study suggests that physicians are not, in the course of their training, either learning about the efficacy of routine testing or learning to order fewer routine tests as they achieve greater experience.

### The Charlotte Experience

House officers in Charlotte, N.C., participated in a program designed to reduce costs of unnecessary laboratory procedures. Each house officer routinely reviewed all inpatient and outpatient bills generated on his service. Findings in this study were that length of stay was reduced an average of 21% during the study and outpatient encounter costs were actually reduced despite steady across-the-board inflation of all test costs. The more ominous findings in the study were that cost and

length-of-stay were *not* appreciably reduced on the private service and that inflation could quite easily eradicate effects of rigorous physician cost-containment efforts.<sup>1</sup>

### Practice with the Government— Good News and Bad

A former Illinois Resident currently on a stint with the Public Health Service reports both good and bad news about cost containment practices within the government. The good news is that government-run health services are no longer spending with a sense of endless reserve. Very strict spending controls are the order of the day. As a result many PHS physicians are evaluating every test carefully before ordering it. So much for the good news. The bad news is that by being locked into careful budget controls, patient care must be triaged to fit into the budget. A test which might be indicated but is not absolutely essential may not be done when the budget is tight—resulting in a different standard of care for PHS patients than might be used for private patients.

A final note on a more ludicrous aspect of cost containment: Current government policy is to curtail all driving on government business in lieu of alternative methods of transportation for PHS employees. The result? In several of the more isolated facilities, health care personnel can charter a *flight* to make a necessary field trip, but they cannot *drive* (at a fraction of the cost of a flight) due to the moratorium on road trips! ◀

1. Lyle, Carl, Bianchi, Harris, and Wood: "Teaching Cost Containment to House Officers at Charlotte Memorial Hospital," *J. Med. Ed.* Vol. 54, November 1979.
2. Greenland, P., Mushlin, and Griner: "Discrepancies Between Knowledge and Use of Diagnostic Studies in Asymptomatic Patients," *J. Med. Ed.* Vol. 54, November, 1979.

\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.





# I M J

Illinois Medical Journal

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## Diagnosis and Management

### Thoracic Aortic Aneurysms

BY RONALD L. MENG, M.D., HASSAN NAJAFI, M.D., HUSHANG JAVID, M.D. and JAMES A. HUNTER, M.D./CHICAGO

*Thoracic aortic aneurysms are life-threatening lesions. The incidence of rupture varies between 15% and 100% depending on location, size and associated symptoms. Untreated rupture carries with it virtually 100% mortality. Surgical repair can be accomplished with low mortality due to recent advances. These include intra-aneurysm graft placement, improved extracorporeal circulation, and improved intraoperative protection against ischemic insult. Clearly, the unpredictable and lethal nature of these lesions dictates elective repair in all satisfactory candidates soon after diagnosis.*

Destruction of the elastic matrix of the media of the aorta reduces its compliance and allows enlargement, resulting in a true aneurysm. Fusiform aneurysms due to syphilis and fungal infection, though common in the past, are presently rare. Congenital aneurysms, only slightly more common, result from jet lesions distal to patent ductus arteriosus, coarctation, long-standing or congenital aortic stenosis, or aberrant right subclavian arteries.

The most common causes of fusiform thoracic aortic aneurysms, however, include cystic medial necrosis, atherosclerosis and trauma. Cystic medial necrosis is a degenerative, non-inflammatory process affecting the elastic matrix of the media. It is the most common cause of ascending aneurysm, and often occurs with other stigmata of Marfan's syndrome. Atherosclerosis is the most common cause of arch and descending aortic

aneurysm. Traumatic aneurysms are increasing in incidence with high speed traffic accidents. The most common sites of injury are at the origin of the left subclavian artery and, less often, the aortic root. Traumatic lacerations may involve the entire aortic wall or simply the intima, such that total aortic disruption or false aneurysm with or without dissection may occur. Unfortunately, 80% of these patients do not reach the hospital alive. The survivors should be evaluated with aortography and operated as soon as possible. If for some reason the acute aneurysm is not repaired and the patient survives, the aneurysm becomes chronic, often calcifies, and follows the same natural history as atherosclerotic lesions.

#### Natural History

The thoracic aortic aneurysm is a life-threaten-

Table 1: Results of Fusiform Thoracic Aortic Aneurysm Repair According to Location

LOCATION	NUMBER OF PATIENTS	PROTECTION	MORTALITY
Ascending Aorta	34	Total bypass with local hypothermia	4(12%)
Above sinus of Valsalva	7		0(0%)
Involving sinus of Valsalva	27		4(15%)
Aortic Arch	4		2(50%)
	2	Circulatory arrest and profound hypothermia	2(100%)
	2	Total bypass with cerebral perfusion	0(0%)
Descending Aorta	50		7(14%)
Thoracic only	31	Partial bypass, shunt	6(19%)
	12	None	0(0%)
Thoracoabdominal	7	Selective shunt, none	1(14%)
TOTAL	88		13(15%)

ing lesion. Its progressive enlargement leads ultimately to rupture which is directly responsible for death in up to 60% of affected patients.<sup>1-3</sup> Certain factors increase the likelihood of rupture, including diameter greater than 6cm, presence of symptoms, and evidence of recent enlargement. Lethality also varies with aneurysm location: descending, ascending, arch, and thoracoabdominal aneurysms are responsible for death in 16%, 32%, 64% and 100% of patients, respectively. Median survival is approximately 2.5 years after diagnosis, and the five year survival for patients with thoracic aortic aneurysms has been reported as low as 15%. This natural history provides two distinct clinical presentations: ruptured versus stable aneurysm.

Aneurysm rupture usually causes such rapid demise as to preclude diagnosis and treatment. Arch and descending aneurysms most commonly rupture into the left pleural cavity, but may erode into esophagus or tracheobronchial tree with subsequent exsanguination. Ascending aneurysms may rupture into the pericardium, causing fatal pericardial tamponade. Unfortunately, rupture may be the first indication of the lesion.

Clinical symptomatology or chest roentgenography may provide diagnosis of stable thoracic aneurysms. Compression of neighboring structures by the aneurysm may cause pain, dysphagia, dyspnea, hoarseness, diaphragm paralysis, Horner's syndrome, or venal caval obstruction. Aortic enlargement usually causes roentgenographic evidence of mediastinal widening. Although these aneurysms may show merely gradual enlargement

on serial chest roentgenograms, providing satisfactory opportunity for evaluation and treatment, they may also enlarge so rapidly that surgical repair must be emergently performed. One such example is that of a 70-year-old man who underwent repair of a ruptured abdominal aortic aneurysm and was to return in six weeks for repair of a known, associated descending thoracic aortic aneurysm. The onset of severe chest pain prompted emergent readmission far sooner, however, and chest roentgenograms revealed rapid enlargement of the aneurysm since discharge. Emergency resection and replacement by tube graft successfully avoided a second aortic rupture.

#### Treatment

With refinements in diagnostic and therapeutic methods, the mortality of surgical repair of thoracic aortic aneurysms has diminished to 15% or less. Since rupture mortality approaches 100% and the risk of repair is less than the incidence of rupture, elective aneurysm resection has become the recommended treatment of these lesions in all reasonably healthy patients.

Angiography is essential in all surgical candidates, and can be performed with minimal risk. Challenges to successful repair include poor quality aorta, severe bleeding, left ventricular strain secondary to brachiocephalic hypertension during aortic crossclamping, and ischemia in the vascular beds which are excluded during repair. Repair is best performed by unroofing the aneurysm after proximal and distal control, replacement by intrasaccular anastomosis of an appro-



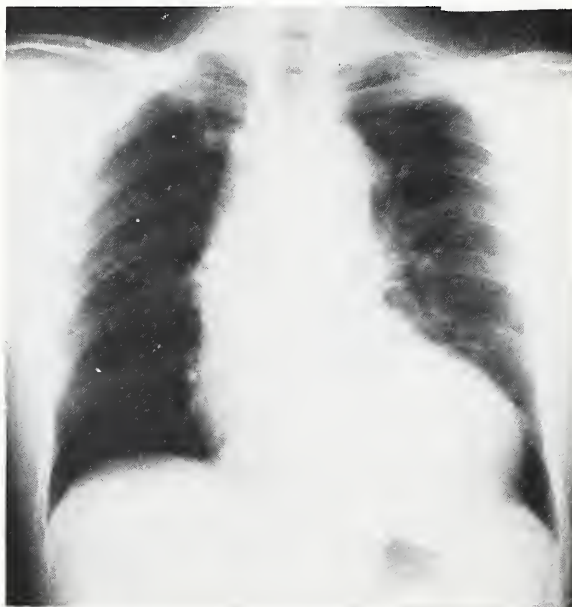
priate graft, and covering the graft with the sac. This technique minimizes dissection, blood loss, and duration of the procedure. Means to prevent left ventricular strain and visceral ischemia vary with aneurysm location and continue to provide the main variation in aneurysm repair technique. Our experience with 88 thoracic aortic aneurysm patients since 1970 (Table 1) forms the basis of this report.

### Ascending Aortic Aneurysms

Ascending aortic aneurysms may be classified according to involvement of the sinuses of Valsalva. Aneurysms limited to the ascending aorta which do not involve the sinuses of Valsalva are usually diagnosed by routine chest roentgenography in asymptomatic patients. They are associated with aortic valvular competence and normal coronary artery ostia and, thus, are relatively easy and safe to repair. We currently employ total cardiopulmonary bypass and myocardial protection by local hypothermia and cardioplegia. Crossclamping distal to the lesion allows the surgeon to open the aneurysm, reconstruct the diseased segment with a dacron graft, and cover the graft with the aneurysm sac. This usually requires less than 60 minutes of cardiopulmonary bypass and invariably provides excellent results.

All seven patients so treated survived with uneventful postoperative courses.

All ascending aortic aneurysms are life threatening because of rupture risk, but aneurysms in-



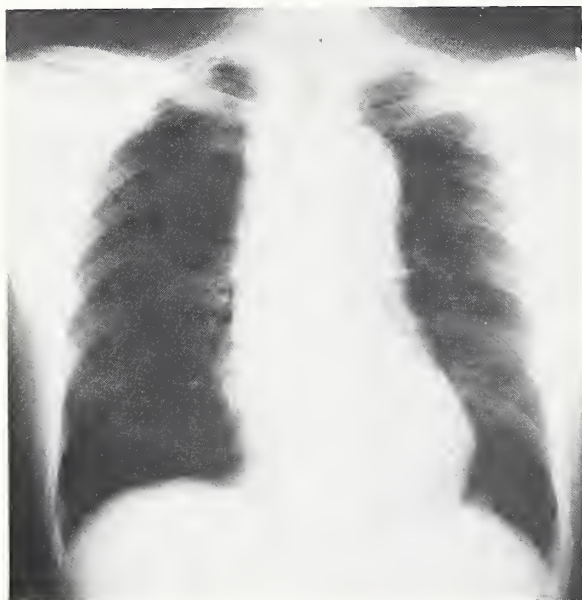
**Figure 1**

The anteroposterior chest roentgenogram reveals aneurysmal dilatation of the ascending aorta.



**Figure 2**

The thoracic aortogram reveals aneurysmal involvement from aortic valve to just proximal to the left subclavian artery.

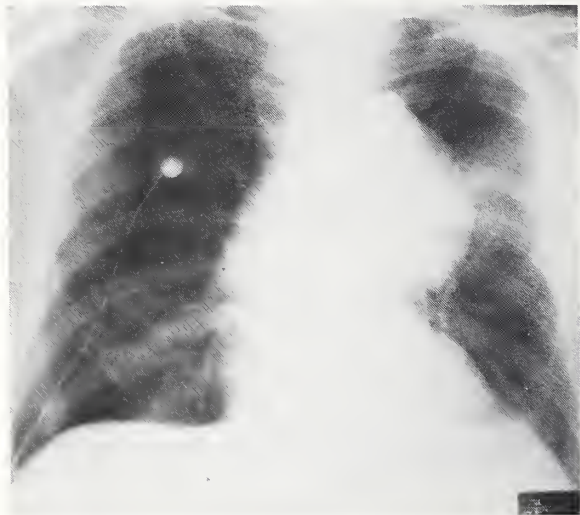


**Figure 3**

The current, one year postoperative chest roentgenograms reveal stable aortic size and configuration and appropriate position of aortic valve prosthesis.

volving the sinuses of Valsalva are additionally lethal because dilatation of the aortic annulus causes aortic valve incompetence and fulminant congestive heart failure. This is the leading clinical manifestation of these aneurysms and is responsible for most diagnoses. The proximal dilatation of the sinuses of Valsalva also causes variable superior displacement of one or both coronary ostia. Thus, this variety of ascending aneurysm is much more challenging to repair.

Proper management demands attention to the aneurysm, the aortic valve, and the coronary ostia. If the left coronary ostium is not displaced, the preferred repair employs separate valve and graft replacement without disturbance of the left coronary ostium but transplantation of the right coronary ostium either directly or via short saphenous vein graft to the aortic graft.<sup>4</sup> If both coronary ostia have been displaced, however, we prefer composite valve-graft replacement with bilateral coronary artery transplantation.<sup>5</sup> The excision of all aortic tissue superior to the annulus and the ease of coronary revascularization are responsible for the success of composite grafting. When performed during total cardiopulmonary bypass with femoral artery perfusion (to avoid cerebral and visceral ischemia) and cardioplegia (to avoid myocardial ischemia) results are excellent.



**Figure 4**

The chest roentgenograms reveal massive enlargement of the aorta in the region of the prosthetic graft.

### Aortic Arch Aneurysms

Arch aneurysms carry very poor prognosis, and they are the most formidable to repair. The usual problems include necessarily extensive and prolonged dissection and poor brain and heart tolerance to decreased perfusion. Our two most recent patients underwent successful repair under total cardiopulmonary bypass with moderate systemic hypothermia and selective brachiocephalic perfusion,<sup>6</sup> and in our hands this remains the procedure of choice.

Uncommonly an ascending aneurysm may involve the aortic arch as well. One such patient was a 49-year-old man with severe calcific bicuspid aortic stenosis. (Figure 1) The aortogram revealed aneurysmal dilatation from the aortic valve to the left subclavian artery. (Figure 2) At surgery, the aorta was controlled between left common carotid and left subclavian arteries and the brachiocephalic vessels were controlled as well. Hypothermic right atrial-femoral artery cardiopulmonary bypass with topical myocardial hypothermia and cardioplegia was complemented by selective perfusion of both common carotid and right subclavian arteries. First, the aortic valve was replaced by a porcine xenograph. A 35mm dacron graft was then anastomosed just proximal to the left subclavian artery in an oblique fashion, so as to maintain an aortic cuff containing the brachiocephalic branches. The establishment of flow through this graft from the perfused femoral artery allowed removal of the perfusion catheters from the brachiocephalic vessels after only 21





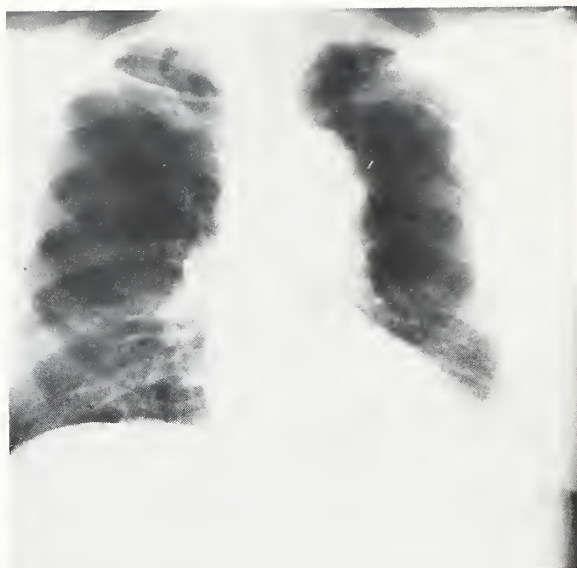
**Figure 5**

The thoracic aortogram demonstrates a large recurrent false aneurysm suggestive of disruption of the anastomotic suture line.

minutes of selective perfusion. Finally, the proximal anastomosis was made at the level of the commissures since the aneurysm did not involve the sinuses of Valsalva. The repair was completed within 83 minutes of total aortic cross-clamping. The patient had an uncomplicated postoperative course and is healthy and working one year later. (Figure 3)

#### **Descending Aortic Aneurysms**

The descending aorta is the most common location of thoracic aneurysm. Most are limited to the supradiaphragmatic aorta. The major complications of their repair include paraplegia and renal failure due to hypoperfusion of the spinal cord and kidneys and acute left ventricular strain due to proximal hypertension. Various methods have been applied to avoid these problems, including extracorporeal circulation and temporary extravascular shunting. However, normothermic aortic crossclamping without shunting<sup>7</sup> has been utilized successfully in our last 12 descending aortic aneurysm repairs. The only major compli-



**Figure 6**

The current, one year postoperative chest roentgenograms reveal stable aortic size and configuration.

cation occurred in a patient who had suffered acute disruption of the proximal descending aorta in a motorcycle accident. The resulting false aneurysm was actively bleeding into the left pleural cavity. Although the aorta was cross-clamped for only 26 minutes, he demonstrated postoperative weakness and sensory loss related to lower lumbar spinal cord ischemia. He then began gradual recovery and is currently able to walk without a cane. Another patient, a 66-year-old male, had survived repair of a ruptured abdominal aneurysm and, 10 years later, elective resection and graft replacement of a descending aortic aneurysm. He returned six months later with massive hemoptysis. Chest roentgenograms showed tremendous enlargement of the aorta at the site of the previous operation, (Figure 4) and the thoracic aortogram suggested disruption of the proximal suture line with formation of a false aneurysm. (Figure 5) At surgery, the graft was found totally separated from the aorta, involved in an aortobronchial fistula, and surrounded by pus which grew *Candida Albicans*. After evacuation of all pus and debris and removal of the graft, a new graft was inserted. The patient underwent prolonged treatment with amphotericin B, recovered, and is healthy one year later.<sup>8</sup> (Figure 6)

The thoracoabdominal aneurysms form a distinct subset of descending aortic aneurysms. They are difficult management problems, especially

when multiple abdominal aortic branches are involved. The difficulty lies in obtaining adequate exposure of the proximal and distal margins and all involved branches and repairing the aneurysm with minimum insult to visceral and spinal perfusion. Although the duration of visceral ischemia is somewhat longer with simple aortic crossclamping than with other techniques, the complication rate is not greater, and the operation is much more expeditiously performed.<sup>9</sup>

We have used simple crossclamping and grafting with individual branch reconstruction in seven patients with only one postoperative death. One patient, a 62-year-old woman, had surgery for an aneurysm extending from the left subclavian to the superior mesenteric artery. The aorta was clamped distal to the left subclavian artery and distal to the renal arteries, and the renal, superior mesenteric and celiac arteries were clamped as well. Restoration of aortic continuity by insertion of a long tube graft from distal to the left subclavian artery to just proximal to the superior mesenteric artery required 42 minutes of aortic crossclamping. A button containing the celiac orifice was then transplanted to the graft within eight minutes. The patient recovered uneventfully.

We have found that certain technical considerations improve ease of repair in these descending aortic aneurysms: (1) a double-lumen endotracheal tube allows deflation of the left lung for improved exposure and gentler retraction, and is easily replaced by a straight tube for postoperative ventilatory support; (2) minimizing bleeding by cautious use of heparin and limited dissection reduces transfusion requirements and coagulopathy; and (3) patch grafting of the anterior aorta may spare intercostal arteries in order to further reduce the incidence of postoperative paraplegia.

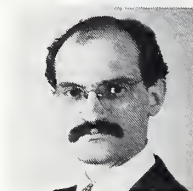
### Summary

During the seven year period beginning January, 1970, we repaired 88 thoracic aortic aneurysms with a 15% overall mortality. Since 1974, earlier detection of the lesion, a more vigorous diagnostic approach, and improved surgical technique and postoperative management have reduced mortality to 6.5%. Thus with early diagnosis and skillful repair, thoracic aortic aneurysms can be corrected with acceptable risk to provide good long-term results.

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## 1,002 Surgery Cases

# Geriatric Discharge Planning And Follow-Up

By ROSE PODOLSKY, M.A., A.C.S.W. AND JAMES H. MASON, M.D./EVANSTON

*In 1975, a prospective study of discharge plans of 1,002 elderly surgical patients hospitalized in our 459 bed facility was implemented. The objectives were to determine specific kinds of community support these elderly surgical patients would need in order to return home. For the purposes of this study, these patients were grouped in three categories by age: 60's to 70's, 70's to 80's, and over 80 years of age. When the medical social worker became involved with specific patient who were selected for discharge planning, consideration was given to all relevant factors in the patient's total situation. These included the patient's diagnosis, special medical needs, patient's participation in discharge plan, marital status, financial situation, role of relatives and specific supports available in the community.*

One of the goals of this study was to contact every patient directly. The patient was to be actively involved in the decision making process at the level where he was able to function. If this approach was not possible, contact was initiated with a patient's spouse, relative or close friend, to carefully assess present life adjustment. If discharged to a nursing home, follow-up was initiated to determine length of stay in that facility. If the patient had expired in the institution, then the length of time he was in the facility was determined.

In the total group of 1,002 patients, 422 were in their sixties. Three hundred and forty-four patients of this group are living at home; 199 of these with their spouses, 133 independently and 12 with their families. Generally, they were in relatively good health and coping well. Three patients were utilizing in-home health services. Seventy patients had expired. Only eight patients of the original group were placed in nursing homes. Of these eight, three patients expired from 3 days to 10 weeks after placement in the facility.

From the total group, 376 patients were in their seventies. Of these, 242 are presently living at

home, 108 patients are living with their spouses, 107 independently and the remaining 27 with their families. Six patients receive supportive help. One hundred and eight patients had expired. A total of 26 patients were in nursing homes. Twelve had expired one week to four months after placement. It is important to emphasize that only our sickest patients received nursing home placement, and as a result, the high mortality rate is not unexpected.

With proper selection and careful placement, it is apparent that most surgical patients entering a nursing home will spend the rest of their lives there. A few notable exceptions were encountered in this study. For example, a 75-year-old female who had undergone bilateral above-knee amputations and who cherished independent living thought it was impossible to live independently again. Her only relative was an elderly cousin who visited occasionally. The patient did have an opportunity to benefit from services at the Rehabilitation Institute of Chicago. She learned wheelchair independence and eventually could walk with two prostheses. A combination of in-home health and supportive services, including moving to an elevator building, were arranged by the Council of Jewish Elderly.

A total of 204 patients were in their eighties and nineties. Eighty-eight patients are presently at home; 15 are living with their spouses, 36 live independently and 37 with their families. Eighty-six patients had expired. Thirty patients were placed in nursing homes. Of these, 16 expired within 18 months.

### Summary

Because too little research has been done on the last phase of life, we are not adequately pre-

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### Discharge Experience: 1,002 Geriatric Surgical Patients

	Age 60	Age 70	Age 80 +
Original Group	422	376	204
	133 (alone)	107 (alone)	36 (alone)
Living Independently	199 (with spouses)	108 (with spouses)	15 (with spouses)
	12 (with families)	27 (with families)	37 (with families)
Dead	70	108	86
Nursing Home	8	26	30

pared for the increased survival of millions of Americans. Concern for the extension of life must carry in tandem an equal amount of effort to improve its quality. Sound discharge plans can add immeasurably to longer and more satisfying lives in the over-60 age group in our population.

In summary, a prospective study was made of 1,002 surgical patients' discharge planning. It has been gratifying to note that the majority of

these patients returned to their homes. Only 6.3% ever received nursing home care. ◀

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Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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lowing style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.



June 25, 1980

Chicago

## Second Fetal Alcohol Syndrome Conference Announced

The Second Annual Fetal Alcohol Syndrome (FAS) Conference will be held on June 25, 1980, at the University of Illinois' Chicago Circle Center, 750 S. Halsted.

For the second year, ISMS has joined with the Governor's Citizens Advisory Council on Alcoholism, the State Health Coordinating Council, Illinois Association of Retarded Citizens, Chicago Association of Retarded Citizens, Illinois Nurses Association—Chicago Chapter, University of Illinois School of Nursing, and Lutheran General Hospital in co-sponsoring the event.

Because of a continuing problem of awareness and knowledge in this area by the helping professions and the general public, and because FAS is preventable, the sponsoring organizations believe that a follow-up conference of this type is needed to broaden the base of relevant information about FAS.

This year's conference will feature many recognized researchers and clinicians. Their active experience includes diagnosis and treatment of Fetal Alcohol Syndrome, working with the families of children with FAS and efforts in prevention. The following is a partial list of the faculty:

### **The present status of fetal alcohol syndrome**

- Henry Mangurten, M.D., Director of Neonatology, Lutheran General Hospital
- Geraldine K. Piorkowski, Ph.D., Region 2 Consultant on Alcoholism Training, Illinois Department of Mental Health and Developmental Disabilities.

### **Using the volunteer network for FAS education**

- Leverne Clark, R.N., M.S. Ed., California Women's Commission of Alcoholism, Los Angeles

### **Paternal influence in fetal alcohol syndrome?**

- Murray Feingold, M.D., Center for Birth Defects, Department of Pediatrics, Tufts New England Medical Center, Boston

### **Fetal alcohol effects: research and clinical issues**

- Cynthia S. Herman, Ph.D., Director of Child Services, Pregnancy and Health Program, University of Washington, Seattle

### **Mouse-model research: implications for treatment**

- George Lambert, M.D., neonatologist, Dept. of Pediatrics, Michael Reese Hospital and Medical Center
- Alvin Kotake, Ph.D., University of Chicago

### **Management of the alcoholic woman during pregnancy**

- John N. Chappel, M.D., F.R.C.P. (Canada), Professor of Psychiatry, University of Nevada School of Medical Sciences, Reno

### **Issues in perinatal addiction**

- Ira J. Chasnoff, faculty member, Northwestern University Medical School, consultant pediatrician to the Perinatal Addiction Program, Northwestern Memorial Hospital
- Gay Diggs, R.N., Perinatal Addiction Coordinator, Northwestern Drug Dependency Program
- Mary Haack, R.N., M.S., Northwestern Drug Dependency Program

### **Intervention and treatment techniques**

- Dolores W. Niles, ACSW, Center for Alcohol and Other Drug Services, Madison, Wisconsin

### **Parent counseling and introduction to mourning**

- Kenneth L. Moses, Ph.D., private practice, Chicago

### **Additional speakers to be announced.**

Hour for hour category 1 continuing medical education credit will be available to participants. For further information, contact Emma C. Redmond, or Ila Sue Goldberg, Division of Alcoholism, Illinois Department of Mental Health and Developmental Disabilities, (312) 793-2907.

# Seminars in Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

## Viruses, Interferon and the Immune Response

BY HOWARD M. JOHNSON, Ph.D./TEXAS

*Interferons are increasingly recognized as having pleiotropic-like effects on cell function. These effects may be expressed in the form of antiviral, anticellular, immunoregulatory, and antitumor activities. Interferon was discovered in 1957 by Isaacs and Lindenmann, and this discovery was based on its antiviral properties with a view toward understanding the nature of host defense against viral infections. It follows that most definitions of interferon include its description as a glycoprotein secreted by virus-infected cells which promotes establishment of an antiviral state in uninfected cells. In this brief overview of the interferon field, we shall attempt to convey the present day meaning of interferon in the context of its varied biological activities. Where possible, review articles will be cited, and these can serve as a source of original articles.*

### The Antiviral Property of Interferon

The production and action of virus-induced interferon at the cellular level is depicted in Figure 1.<sup>1</sup> During early stages of cellular viral infection, some event (probably the presence of foreign viral nucleic acid) derepresses cellular genes located on specific human chromosomes which contain the stored genetic information for the interferon protein. Interferon is produced by transcriptional and translational events as occur in normal protein synthesis. The produced interferon does not inactivate the virus by direct interaction. Rather, it leaves the cell and then reacts with a specific receptor on the cell membrane of the producing and surrounding cells. This membrane interaction results in the derepression of a

gene(s) that codes for the antiviral proteins. The intracellular antiviral proteins are thought to be involved in actual inactivation with virus. We shall examine possible identity and mechanism of action of the antiviral proteins.

The interferon system is nonspecific in that it is activated by a variety of viruses and the interferon produced induces cellular resistance against a broad range of viruses. Interferon is the earliest appearing of the known host defenses against viral infections and probably plays an important role in the initial phases of the host protective response. Figure 2 illustrates the early production of interferon in comparison with antibody during experimental infection of man with influenza virus. This early appearance of interferon has been shown to be important in the ultimate outcome of virus infection. Under experimental conditions of viral infection in mice, where the produced interferon is neutralized by passively administered anti-interferon antibody, the viral in-

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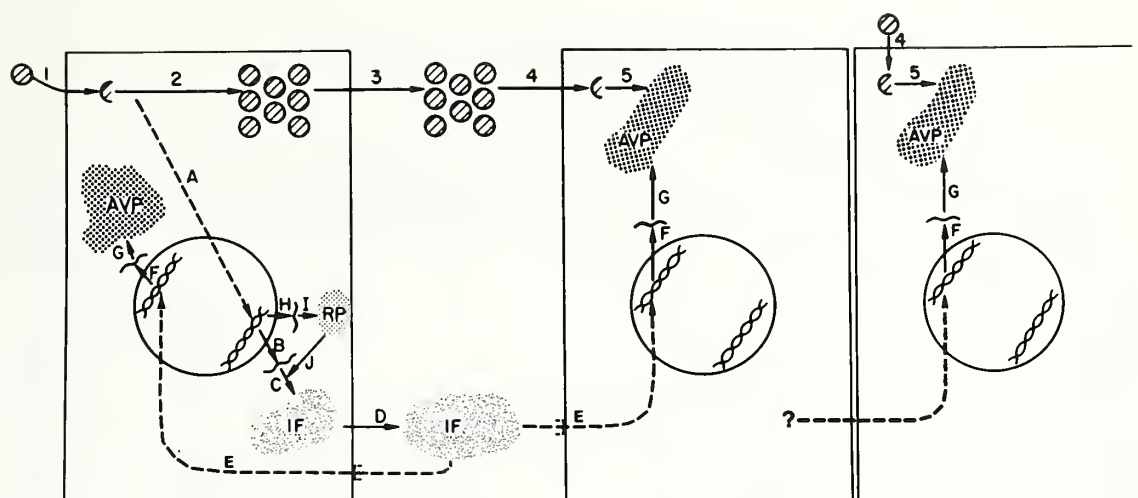


Figure 1

Cellular events of the induction and action of interferon (IF). Virus comes in contact with the cell<sup>1</sup> and penetrates the cell membrane. The virus then releases its genetic material, and replication of the virus occurs.<sup>2</sup> The new virus leaves the cell,<sup>3</sup> enters the fluid around the first cell, and some of the replicated virus infects a second cell,<sup>4</sup> where the release of the genetic material again takes place.<sup>4</sup> During the early stages of infection of the first cell, some event (viral nucleic acid?) stimulates a gene in the DNA which contains the stored genetic information for interferon (A). This leads to the production of a messenger RNA for interferon, which leaves (B) the nucleus and is translated by the cell's ribosomes (C) into the interferon protein. Several events now occur more or less simultaneously. Interferon is secreted by the first infected cell (D), enters the surrounding fluid, where it comes into contact with and stimulates the second cell (E) by interacting with a membrane receptor for interferon. The second cell is thereby induced to produce a new messenger RNA (F) which is translated to a new protein(s) (G), the antiviral protein (AVP). This in turn modifies the cell's protein-synthesizing machinery, such that cell mRNA is translated into protein but viral RNA is poorly bound or translated, or both. In the first cell processes, E, F, and G may in some instances, also operate to form AVP and thereby reduce the virus yield in the first cell. Shortly after interferon is synthesized into the first cell another mRNA (H) is believed to be synthesized from the cell's DNA which is translated (I) into a regulatory protein (RP) (hypothetical). This regulatory protein combines with the mRNA for interferon thereby preventing the further synthesis of more interferon (J). There is recent evidence that the antiviral state may be directly transferred between adjacent cells (from second to third cell at right) by the passage of an unknown (?) inducer of the AVP.

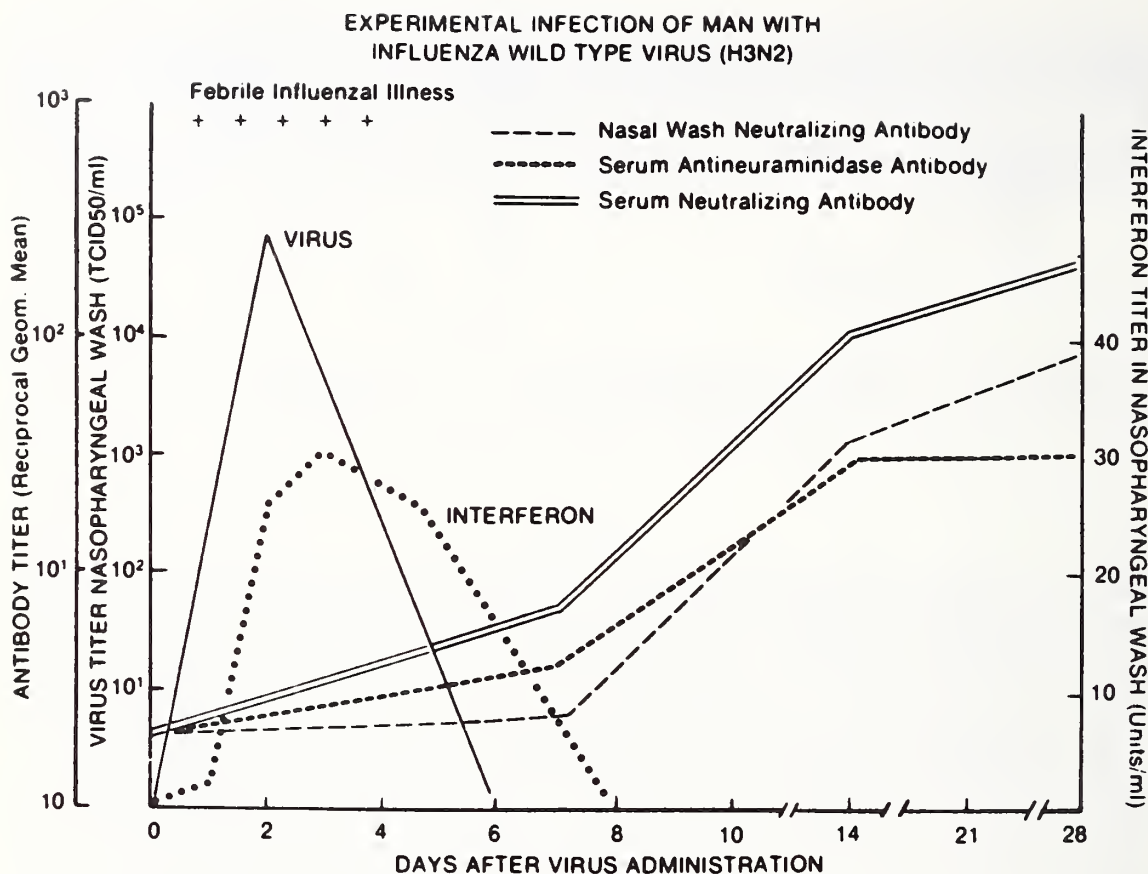
fections are significantly more severe, with dramatic increases in animal deaths. Interferon, then, is probably very important as a natural host defense against viral infections.

### Molecular Aspects of the Action of Interferon

Currently, it is not known precisely how interferon inhibits viral replication. Data have been presented which suggest both a block of transcription of viral RNA and/or inhibited translation of viral proteins. Inhibition of protein synthesis is currently felt to be the primary mode by which interferon exerts its varied biologic effects.

Two mechanisms (Figure 3) by which interferon inhibits protein synthesis have been examined by a number of laboratories.<sup>2</sup> One mechanism involves induction of a protein kinase, which in turn catalyzes the phosphorylation of one of the initiation factors (eIF-2 subunit) that

is required for protein synthesis. (eIF-2 is inactive in the phosphorylated state.) The second mechanism involves interferon induction of a polymerase, called 2'-5'A synthetase. This enzyme, in the presence of double stranded RNA, converts ATP to a 2'-5'-linked oligoadenylate(s) (2'-5'A). 2'-5'A activates an RNA endonuclease, which catalyzes the degradation of RNA. Destruction of messenger RNA by this enzyme results in inhibition of cellular protein synthesis. Both the protein kinase and endonuclease activities may play a role in a variety of interferon mediated biological activities. These include inhibition of viral replication, suppression of the immune response, and anticellular effects such as inhibition of tumor growth. Certainly, the antiviral protein(s) that has been described above may be represented by the protein kinase and RNA endonuclease systems.



**Figure 2**

Production of virus, interferon, and antibody during experimental infection of man with influenza wild type virus. (From study by B. Murphy, et al., National Institutes of Health).

### Classification of Interferons

Although often presented and discussed in the singular, there are actually several types of interferons (Table 1).<sup>1</sup> Interferons may be classified into two broad groups, virus-type (type I) and immune-type (type II). Virus-type interferons are classically induced by viruses or double-stranded polyribonucleotides. In the human system, and perhaps the mouse system also, there are at least two antigenic types. They are called fibroblast and leukocyte interferon to indicate their primary or predominant cellular origin. Another interferon, lymphoblastoid interferon, which is produced by a transformed human cell line, is thought to be a mixture of leukocyte and fibroblast interferon. Recent amino acid sequencing data of various virus-type interferons may eventually require further classification of these interferons. Of recent interest is the observation that leukocyte interferon can be induced in some

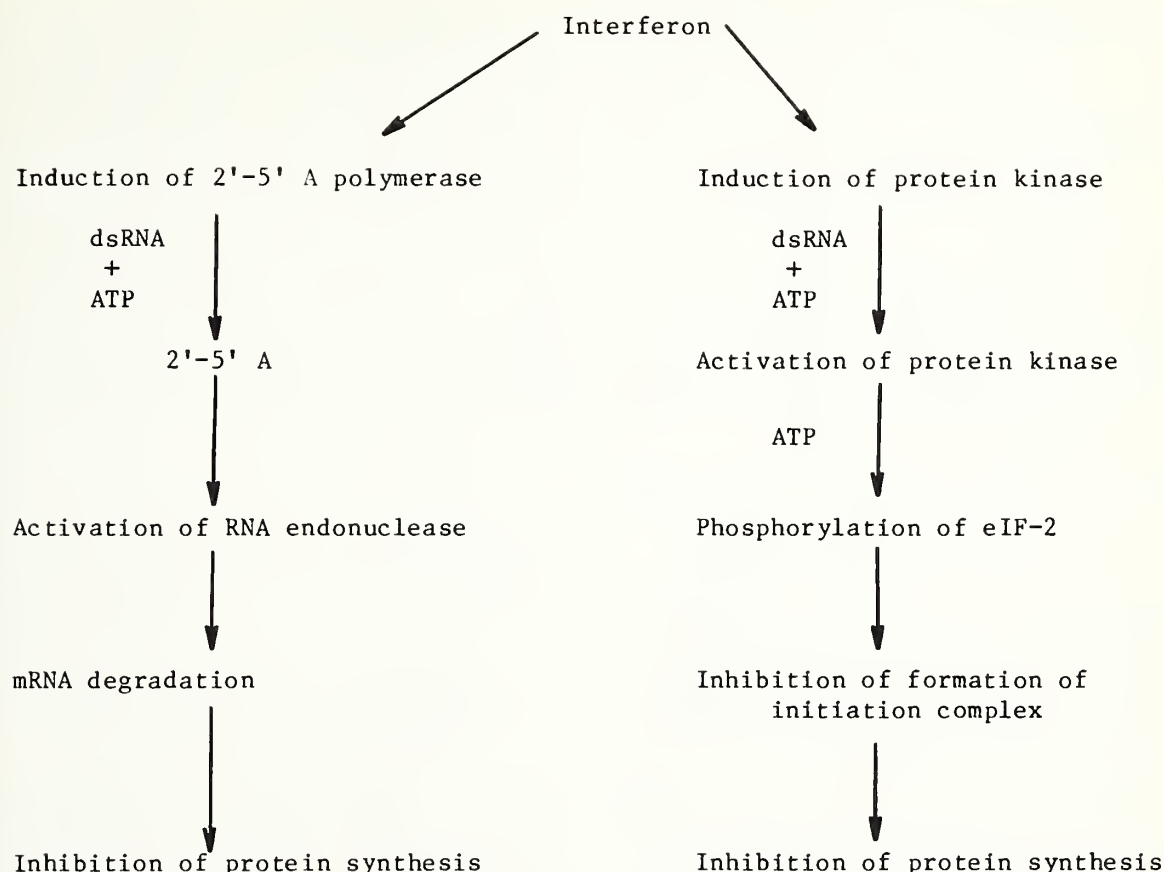
lymphoid cell subpopulations by tumor cells. This may have some relationship to the antitumor properties of interferon, and could possibly represent a host defense response against spontaneous tumors.

Immune interferon (immune-type) is either induced in primed T lymphocytes by subsequent exposure to the specific antigen or in unprimed T lymphocytes by T cell mitogens such as phytohemagglutinin, concanavalin A, and staphylococcal enterotoxin A. Immune interferons induced in the mouse systems either by antigen or by several T lymphocyte mitogens are antigenically the same or very similar to one another.

### Modulation of the Immune Response By Interferon

Data are quite conclusive that interferon can play a regulatory role in modulation of the im-





**Figure 3**

Schematic representation of the effects of interferon on cellular function. Two well defined pathways have been demonstrated for interferon inhibition of protein synthesis in the cell. One involves activation of an endonuclease and the other involves induction and activation of a protein kinase. See text for details.

mune response at several levels.<sup>3</sup> As a matter of fact interferon is probably the mediator of some forms of suppressor cell activity. Virus-type interferon has been shown to suppress the antibody response in both *in vitro* and *in vivo* systems in the mouse.

The *in vitro* system for antibody production in the mouse consists of the use of dissociated spleen cells, which are made up of B and T lymphocytes and macrophages, all of which are normally required for an antibody response.<sup>4</sup> Addition of a suitable antigen, such as sheep red blood cells (SRBC), to the spleen cells in culture media under defined conditions stimulates the production of antibody-forming cells. The antibody-forming cells are enumerated by mixing them with a high concentration of SRBC (10%) in a soft agar medium at 37°C for 1 or 2 hours. During

this incubation, the antibody that is produced by the cells binds to surrounding SRBC. Addition of guinea pig serum, which contains complement, to this complex results in lysis of the SRBC. Thus, a plaque or zone of hemolysis surrounds a cell that is producing antibody to SRBC. The antibody-forming cell is frequently referred to as a plaque-forming cell (PFC), and the antibody response to SRBC is spoken of as the anti-SRBC PFC response. This system has been of considerable value in looking at a variety of events related to regulation of the antibody response. Advantages over *in vivo* experiments are economy of reagents and better control of the microenvironment of the antibody-forming cell.

To determine the effect of interferon on the *in vitro* PFC response, purified interferon is added to the culture at the time of SRBC addition. Five

**Table 1**  
**Classification of Interferons**

**A. Virus-type (Type I)**

1. *Antigenic types*

- a. Fibroblast and epithelial cell origin
- b. Leukocyte cell origin

2. *Inducers*

- a. Viruses
- b. Polyribonucleotides
- c. Chemicals (Tilorone, etc.)
- d. Tumor or heterologous cells (leukocyte interferon)

**B. Immune-type (Type II)**

1. *Antigenic types—only one type known to date*

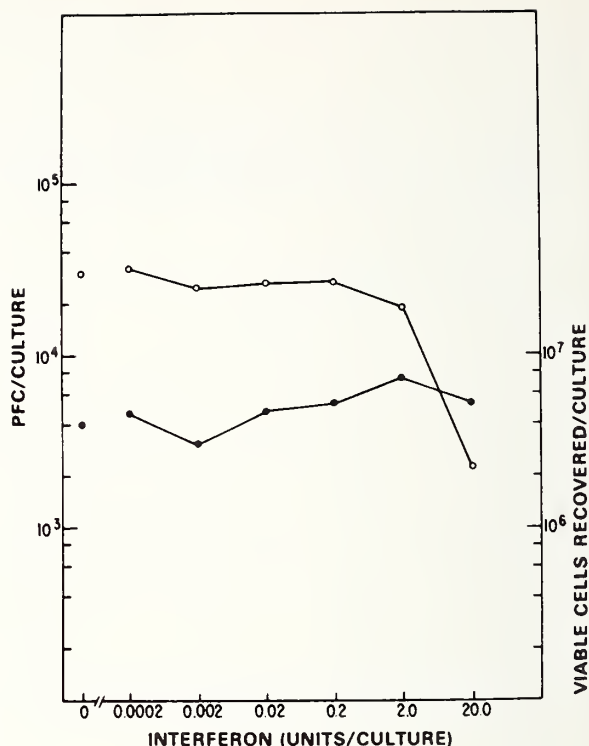
2. *Inducers*

- a. Antigens
- b. Mitogens (primarily T cell mitogens)

days later, the cells are harvested and examined for the PFC response to SRBC. Results of a typical experiment are presented in Figure 4.<sup>3</sup> Virus-type interferon suppressed the *in vitro* PFC response by approximately 99%. Interferon is responsible for the suppression, since it is observed with interferon purified to homogeneity and is specifically blocked by pretreatment of the interferon with specific antibody. In general, 20-60 units of interferon/ml will suppress the *in vitro* PFC response by 90% or more. This represents less than 0.05 nanograms of interferon/ml. This is very potent immunosuppression. Interferon similarly suppresses the antibody response in the mouse, but this requires relatively more interferon (50,000 units or more) and it is impossible to control the concentrations of interferon in the microenvironment of the antibody-producing cell.

**Conclusion**

We may summarize some of the findings to date on the suppressive effects of interferon on lymphocyte function. Interferon is most effective when added to the system at the time of antigen addition. Secondary antibody responses are also suppressed. The suppression of the antibody response could be due to a direct or indirect effect of interferon on the B cell, the cell actually responsible for antibody production. We do have data that show that the B cell response can be suppressed indirectly by interferon, through interferon induction of a suppressor cell, which releases a soluble factor that actually acts on the B cell.<sup>5</sup> This does not preclude a direct effect of interferon on B cells. There is also data which show that the mechanism by which inter-



**Figure 4**  
The effect of highly purified mouse ascites tumor virus-type interferon on the primary *in vitro* PFC response. Direct anti-SRBC PFC/culture (○—○) and viable cells recovered per culture (●—●) were determined on day five.

feron suppresses the immune response is through the protein kinase and endonuclease systems.<sup>6,7</sup> Interferon can suppress the cellular immune response in a manner similar to suppression of the antibody response.<sup>3</sup> It can also enhance the killing of T killer lymphocytes. Further, lymphocytes (null cells) that are neither B nor T cells can be stimulated by interferon to have increased killing activity against tumor cells.<sup>8</sup> Thus interferon may modulate the immune system to have increased antitumor activity. These findings may be related to the reported successful use of interferon as an antitumor agent in certain human cancers. The possible sites of interferon action on the immune system are presented as a working model in Figure 5.

The above summarized data are being amplified and, in some cases, modified by the feverish research currently going on at both the basic and clinical levels. Thus, the statement of the pleiotropic-like effects of interferon on cell function at the beginning of this article is quite justified. ◀



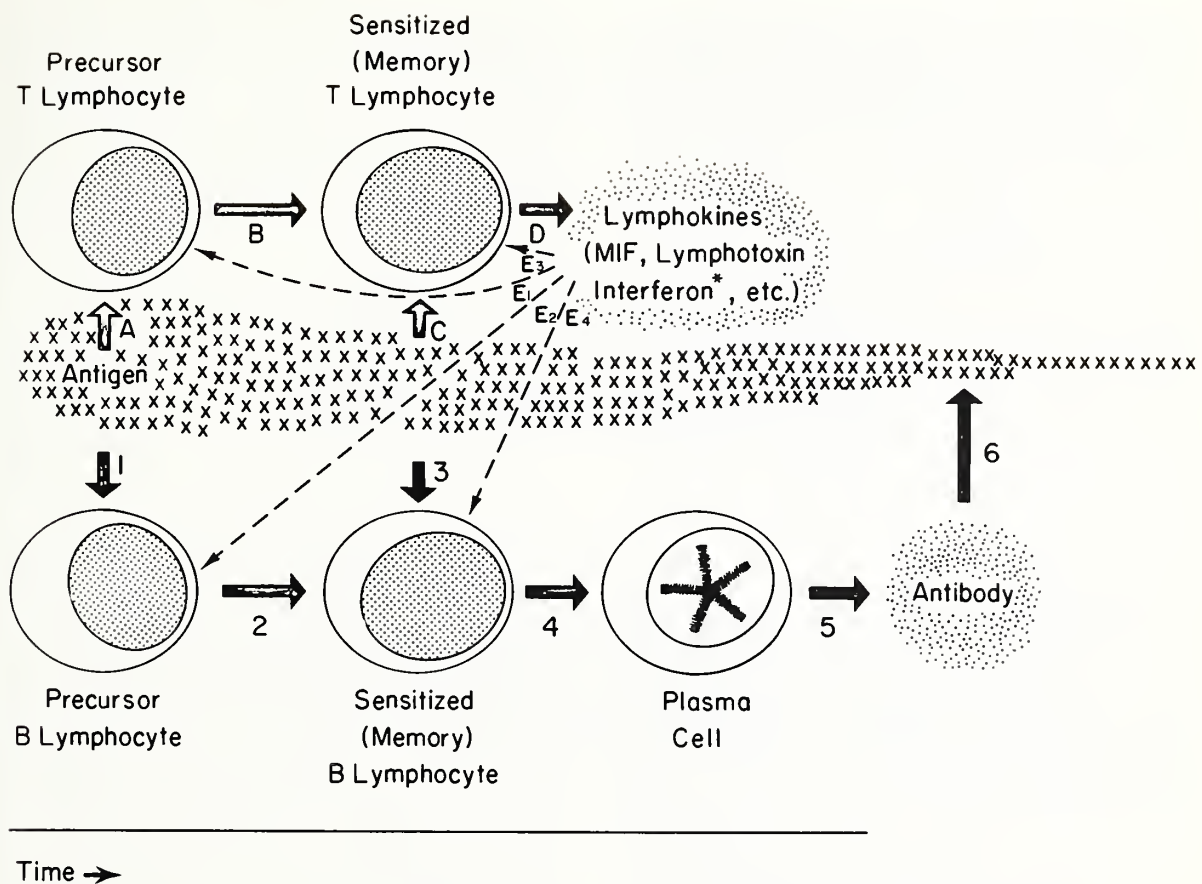


Figure 5

Cellular events in the induction and immunosuppressive action of interferons. Antigen comes into contact with a precursor T lymphocyte (A), which undergoes differentiation to a sensitized T lymphocyte (B). This cell, driven by antigen (C), may become a memory cell or it may release mediators known as lymphokines (D). Among the mediators produced by the T lymphocyte is immune-type interferon. Antigen also reacts with a precursor B lymphocyte (1), which undergoes differentiation to a sensitized B lymphocyte (and memory B cell) (2). The sensitized B cell is further driven by antigen (3) to become a plasma cell (4), which is responsible for most of the antibody (5) that is produced. This antibody reacts with the specific antigen (6). Both antigen- and virus-induced interferons are capable of suppressing precursor T ( $E_1$ ) and B ( $E_2$ ) lymphocytes as well as sensitized T ( $E_3$ ) and B ( $E_4$ ) lymphocytes. As differentiation progresses, in part as a result of continued antigen presence, it becomes progressively more difficult to inhibit lymphocyte function by interferons. Plasma cell production of antibody is resistant to inhibition by interferon. The macrophage is not included in the figure, but interferons may exert their immunosuppressive effects via a required macrophage function in the immune response. The diagrammatic scheme does not necessarily imply, therefore, a direct effect of the interferons on the lymphocytes.

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**A Joint Statement of the Drug Enforcement Administration  
And the DEA/Practitioners Working Committee**

## **Guidelines for Prescribers Of Controlled Substances**

*The following guidelines were adopted by the American Medical Association House of Delegates at their 1979 Interim Meeting.*

*In reading the guidelines, members are reminded of a recent pertinent amendment to the Illinois Controlled Substances Act. (Related story on page 302)*

*The following is a verbatim reprint of the Guidelines captioned above, as adopted by the AMA House of Delegates, 1979.*

### **Preface**

The following embodies the collective thinking of members of the DEA/Practitioners Working Committee. First formed in 1974, this Committee has provided a forum for DEA officials and association executives and practitioners to meet voluntarily to discuss items, issues, and subjects of mutual interest, areas of practical concern, and generally maintain an open and responsive attitude among the various members. Having no intrinsic authority, and seeking none, the DEA/Practitioners Working Committee believes it has played a significant role in promoting the generally harmonious relationships which exist between its national organizations and their respective members. It is against this background of shared experience and knowledge that participants in the work of this Committee offer these "Guidelines for Prescribers of Controlled Substances" to members of the professions throughout the country.

### **Purpose**

The purpose of this joint statement and the presentation of guidelines is to provide and establish acceptable professional responses to the de-

mands of the Controlled Substances Act. The guidelines provide a common sense approach to encourage voluntary compliance by the prescribing professions.

### **General Statement**

The principles expressed in these guidelines constitute neither a pronouncement of law nor a code of ethics, and are not intended to in any way supersede or be in conflict with statutes or ethical concepts governing the conduct of the various practitioners in their respective practices or in their respective professional organizations. Accountability is the responsibility of each discipline.

### **Application of State and Federal Law**

Separate laws relating to the distribution of controlled substances have been enacted in most states. In many cases state law is much more stringent than Federal law and will not allow certain practices which may be authorized under Federal law. The guidelines are an example of good practices which should be encouraged under both Federal and state laws and regulations. Close cooperation and understanding between law enforcement and medicine will ensure that



legitimate drugs remain in legitimate channels.

### **Communication**

Recognizing that members of each profession have special competencies and knowledge concerning drugs and related therapeutic agents, a free exchange of information on these matters is encouraged among the professions at all levels.

### **General Guidelines**

Controlled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well being of patients.

Prescribing controlled substances for legitimate medical uses requires special caution because of their potential for abuse and dependence.

Exercise good judgment in administering and prescribing controlled substances so that diversion to illicit use is avoided and the development of drug dependence is minimized or prevented.

Guard against contributing to drug abuse through injudicious prescription writing practices, or by acquiescence to unwarranted demands of some patients.

Each prescriber is asked to examine his/her individual prescribing practices to ensure that all prescription orders for controlled substances are written with caution.

Make specific effort to ensure that multiple prescription orders are not being obtained by the patient from different prescribers.

### **Guidelines—Prescription Orders**

The prescriber is granted through legal authority the right to prescribe medications that are necessary for the proper treatment of his/her patients. Prescribing is governed by law and regulations which set minimum standards and requirements. These guidelines, tempered with good moral and ethical considerations, give guidance to going beyond the minimum requirements.

The prescription order must be signed by the prescriber when it is written. The prescriber's name, address, and DEA registration number and full name and address of the patient must be given when prescribing controlled substances.

The written prescription order should be precise and distinctly legible to enhance exact and effective communications between prescriber and dispenser.

The prescription order should indicate whether or not it may be renewed and, if so, the number of times or the duration such renewal is authorized.

Prescription orders for drugs in Schedules III, IV, and V may be issued either orally or in writing and may be renewed if so authorized on the

prescription order. However, the prescription order may only be renewed up to five times within six months after the date of issue.

A written prescription order is required for drugs in Schedule II. The renewing of Schedule II prescription orders is prohibited. Only in an emergency situation may oral orders for Schedule II drugs be accepted by a dispenser. (*ED. note: In Illinois, an official state triplicate form must be used for "designated products," when prescribed or dispensed.*)

Controlled substances which are prescribed without indication for renewal cannot be renewed without authorization by the prescriber.

Prescribe no greater quantity of a controlled substance than is needed until the next check-up.

Try to make prescription orders alteration-proof.

When prescribing a controlled substance, write out the actual amount in addition to giving an Arabic number or Roman numeral in order to discourage alterations in written prescription orders.

Prescribers are encouraged to consider placing a number of checkoff boxes on their prescription blanks which show amounts within which the prescribed amount falls, *i.e.*, 1-25, 26-50, 51-100, over 100.

Use separate prescription blank for each controlled substance prescribed.

The use of prescription blanks which are preprinted with the name of a proprietary preparation should be discouraged.

When institutional prescription blanks are used, the prescriber should print his/her name, address, and DEA registration number on such blanks.

Institutions should discourage the use of institutional prescription blanks for prescribing controlled substances. The prescriber should use his/her own prescription blanks in such instances.

### **Duty to Inform**

The prescriber has the responsibility to inform patients of the effects of the prescribed drugs consistent with good medical practice and professional judgment. The patient has a corresponding duty to comply with the prescriber's directions for use of the prescribed medication.

Each of the professional organizations and the Drug Enforcement Administration has a responsibility to educate and inform the public on proper handling and use of controlled substances. The professions represented on the DEA/Practitioners Working Committee recognize that they have responsibilities to themselves, beyond legal minimum restraints. ◀

# New State of Illinois Regulations Regarding Controlled Substances

*The following report has been published by the Illinois Department of Registration and Education, in order to inform Illinois physicians about recent regulatory changes. This is reprinted as a service to the membership.*

Licensed health-care practitioners who dispense the more dangerous drugs must comply with a new Illinois provision that requires periodic notification to the Department of Registration and Education by means of filling out triplicate prescription blanks.

Formerly, such practitioners had to fill out the triplicate blanks only when the prescriptions for such drugs were filled outside their office at a pharmacy.

Now, however, they must do it, too, when they dispense them—when they hand over a supply of such medication to those they are treating.

The new provision—an amendment to the Illinois Controlled Substances (Dangerous Drugs) Act—does not apply, though, to licensed health-care practitioners who administer such drugs directly to patients and, therefore, do not write a prescription.

Those to whom the new amendment does apply are subject to discipline against their licenses for violations of it.

Explaining the new amendment, Acting Department Director James D. Nowlan stressed that the Department intends to enforce it strictly.

One problem that has arisen, Nowlan said, is that many such triplicate prescription blanks—by which the Department is notified—are partly illegible “and that makes it difficult for the Department to perform its statutory duty of regulating drug providers.”

At present, he said, the Department is analyzing what can be done to improve the illegibility situation.

Under the state's Controlled Substances Act, those who can dispense Schedule II drugs—to which the new provision applies—are medical doctors, dentists, podiatrists and veterinarians.

The new amendment to the Act says that those

health-care practitioners who dispense a designated product in Schedule II “shall do so only upon the issuance of an official prescription blank” and must comply with provisions for reporting it to the Department.

Illinois law provides that a drug be included under Schedule II if:

- The substance has high potential for abuse;

- The substance has currently accepted medical use in treatment in the United States, or currently accepted medical use with severe restrictions; and

- The abuse of the substance may lead to severe psychological or physiological dependence.

Under the provisions for reporting the prescription of Schedule II drugs to the Department, the original and one copy of the official prescription blank are delivered to the person filling the prescription.

The duplicate has to be endorsed properly by the person filling the prescription at the time it is filled, the law says, and the original official prescription is retained by the prescription filler. Thus, a physician must retain the duplicate for filing if he dispenses the medication.

By the 15th of the month following the month in which the prescription is filled, the law says, the duplicate must be returned to the Department.

Further, the law says, the official prescription blanks containing the prescriber's copies of prescriptions issued have to be retained by the prescriber for two years and can be inspected by proper authorities. And, if any of them are lost, the loss has to be reported.

The new part of the law also provides that a practitioner shall not have pre-printed any prescription for a dangerous drug and shall not have issued or filled a pre-printed prescription for such a drug. ◀





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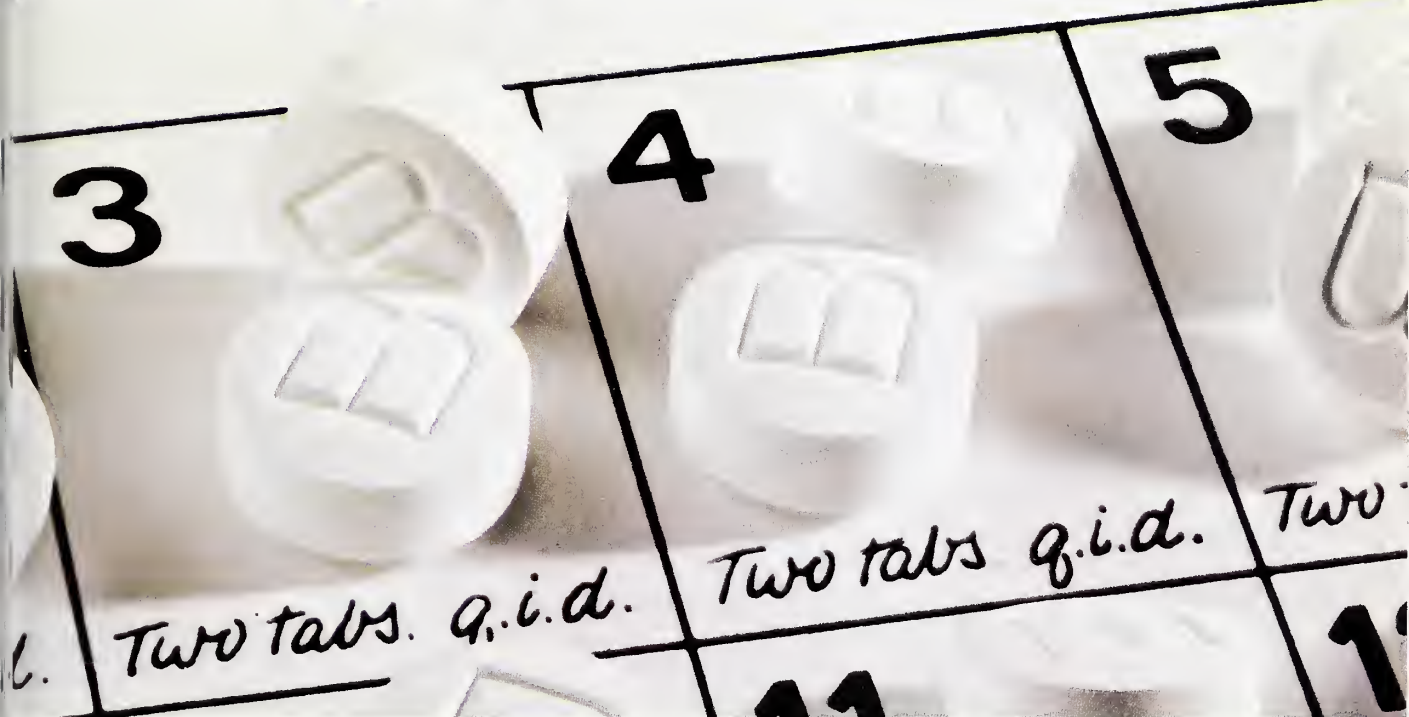
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# President's Page



## An Idea For The 80's: Individual Practice Association

If by IPA you mean something that destroys the traditional doctor-patient relationship . . . an evil that pauperizes the fee-for-service physician . . . a bureaucratic nightmare that handcuffs both patients and doctors . . . a subversion of quality to cost . . . *then I'm against it.*

If by IPA you mean a well-accepted idea whose time has come . . . a system to preserve the traditional practice of doctors in their offices charging fees for individual services . . . the corporate spin-off of a county medical society . . . a marvel of economy that is our profession's answer to escalating health care costs and government intervention . . . *then I'm in favor of it.* ◀

*"Doublespeak:" A perspective that makes results appear better than they really are, and not as bad as they could be.*

*Herschel Browns MD*

Herschel Browns, M.D., President



# Doctor's News

**LICENSE RENEWAL**—License renewal forms were mailed out by the Department of Registration and Education, the second week of April, to all physicians holding Illinois licenses. They were sent to the last address of record of each licensee. If you did not receive a license renewal form, immediately contact the Medical Licensure Section, Department of Registration and Education, 320 W. Washington St., Springfield IL 62786.

License renewal must, by law, be accomplished by July 1, each even numbered year. The past two renewal periods demonstrated that about 10% of current licenses are not renewed on time. This results in a late fee penalty, and also could jeopardize liability insurance coverage during the period a person is practicing with a non-renewed license.

**PHYSICIANS IN THE NEWS**—The Chicago Society of Plastic Surgery recently elected new officers. They are **Martin C. Robson, M.D.**, president, **Richard L. Sperling, M.D.**, vice president, **Norman E. Hugo, M.D.**, secretary and **Randall E. McNally, M.D.**, treasurer.

**Harold A. Sofield, M.D.**, Chicago, was recently awarded the Chicago Medical Society 1980 Public Service Award in recognition of his work as a volunteer with Orthopedics Overseas.

**Herbert Sohn, M.D.**, Skokie was recently named secretary of the Board of Trustees at the University of Health Sciences/Chicago Medical School. Dr. Sohn is immediate past chairman of IMPAC. . . . **Milton Vainder, M.D.**, Evanston, has been elected president of the Chicago Medical School Alumni Association . . . **Lawrence M. Gartner, M.D.**, is the new chairman, Department of Pediatrics, University of Chicago Pritzker School of Medicine. Dr. Gartner, director of the Division of Neonatology and professor of pediatrics at the New York Albert Einstein College of Medicine, will assume the post July 1, 1980.

**GUARDIANSHIP COMMISSION ASSUMES FIRST CLIENTS**—The newly-established Guardianship and Advocacy Commission recently assumed guardianship of its first clients, transferred from the Office of the State Guardian. The Commission, set up as an executive state agency, plays a significant role in a new system for delivery of services to the mentally ill and developmentally disabled. The Commission includes three divisions—Office of State Guardian, Legal Advocacy Service and Regional Human Rights Authorities—with ten regional offices throughout the state, which will open in the next few months. Administrative offices in Chicago are at 123 W. Madison Street, 60602. Telephone calls regarding guardianship cases, or interpretation of the new legislation, may be directed there—(312) 793-5900—or to a temporary number in Springfield—(217) 785-1540.

**BOOKLET ON TAX-SAVING BENEFITS AVAILABLE**—Strom & Associates, 510 Beverly Place, Lake Forest, IL 60045, has announced that complementary copies of a new booklet, "Tax-Saving Benefits for Executives and Professionals," are now available. The booklet outlines options, described as creative ways to channel taxable income into tax-saving benefits. (ISMS does not endorse specific private groups. This is published as a membership service.)

**MENTAL HEALTH CODE GUIDELINES AVAILABLE**—Comprehensive guidelines for implementation of the state's new Mental Health Code are now available from ISMS. The guidelines were developed by the ISMS-sponsored Task Force on the Mental Health Code which was comprised of representatives from ISMS, the Illinois Psychiatric Society and the Illinois Nurses Association.

The guidelines incorporate the latest revisions to the Mental Health Code and offer an explanation of the state's Confidentiality Act and guardianship statutes. The three-ring binder containing the guidelines is designed to allow continued updating as further revisions in mental health law are made by the Illinois General Assembly.

Copies of the guidelines are available at \$15 for ISMS and IPS members and \$25 for non-members. Checks should be made payable to ISMS and sent to the Division for Specialty Societies.

**BCBS URGES CPT IV**—The Chicago-based Blue Cross and Blue Shield Plan is urging Illinois physicians to adopt the AMA "Physicians' Current Procedural Terminology," in an effort to establish a more effective and reliable means of reporting medical services and procedures they perform. CPT is a uniform listing of descriptive terms and identifying codes for reporting medical/surgical services.

Through use of CPT codes when filing claims, payment can be made faster and more accurate. The CPT IV procedure manual can be purchased from the AMA at a cost of \$12.00. A check, payable to the American Medical Association should be sent to: Order Department OP-41, American Medical Association, P.O. Box 821, Monroe WI 53566. Blue Cross has also advised that their Professional Relations Department is available to discuss questions concerning use of CPT IV codes at (312) 661-4489.

**REHABILITATION UPDATE**—A Center for Rehabilitation Information has been established at the Library of the Health Sciences, on the Urbana campus of the University of Illinois. Designed to serve the informational needs of various professionals who work with physically disabled persons, the Center is building an extensive multi-media collection covering all aspects of physical disability and rehabilitation. In late 1980 and early 1981, the Center will sponsor educational workshops for librarians and other professionals throughout Illinois; the workshops will address the obstacles librarians and others face in effectively serving the disabled and offer suggestions for overcoming these obstacles. For further information about the Center, contact Phyllis C. Self, Project Director or Richard E. Bopp, Project Librarian, Center for Rehabilitation Information, Library of the Health Sciences, 102 Medical Sciences Building, University of Illinois, Urbana, Illinois, 61801. (217) 333-4499.

**AMA OFFERS LANGUAGE STUDY FOR FOREIGN-BORN PHYSICIANS**—Beginning July, 1980, the American Medical Association will offer an intensive one-day course to improve English pronunciation. The course is designed to assist foreign physicians now in U.S. practice who seek to improve spoken communication with patients. Sessions will be held July 26 in the AMA headquarters, Chicago. Those who attend will receive formal continuing medical education credit. The course will feature intensive oral drill and criticism of individual students, and practice in sustained discourse through reading and extemporaneous speaking. Course director is Mortimer Enright, head of the AMA Speakers and Leadership Programs Section. Further information may be obtained by writing Henry Mason, Division of Professional Relations, AMA, 535 N. Dearborn, St., Chicago IL 60610. Cost to AMA members is \$130; \$170 for non-members and \$80 for resident physicians. The fee includes a 134-page manual and nine tape cassettes for home study.



# Pulse of the ISMS Auxiliary

## FOOD, FOOTBALL AND FITNESS

BY MRS. R. SAMUEL HOOVER, IMMEDIATE PAST PRESIDENT, ISMSA

At the American Medical Association Leadership Conference in February, Nathan Stark, Undersecretary of the Department of Health, Education and Welfare, urged the AMA to join HEW in a campaign to promote healthier lifestyles. In addition to widening access to health care, Stark said: "We need to promote health in the work place, with an emphasis on curbing the ill health brought on by too much smoking, drinking, and stress, and too little exercise and proper nutrition." The AMA accepted the challenge; the Auxiliary did long ago.

The 1970s have seen a proliferation of programs sponsored by the Auxiliary. The list becomes repetitive, but the 1980-1981 "Shape Up For Life" project certainly fills the bill for the HEW Undersecretary's challenge. The Illinois Auxiliary has met the challenge in 1979 with the new school nutrition program implementation, as well as other health education programs directly relating to a positive focus on nutrition.

Unfortunately no measuring stick has been developed for evaluating preventive medicine programs. The results will not be in until later, and then possibly influenced by factors unknown at present. In some preventive programs, such as the immunization project, dramatic results can be seen, such as the near eradication of smallpox. However, preventive factors influencing such diseases as cancer and coronary disease cannot be nailed down so easily. We may have to wait a generation for evidence of successful preventive programs.

1980-1981 will bring the "Shape Up For Life" program into increased emphasis on *physical fitness*. Thus the Auxiliary joins the formidable line of American exercise enthusiasts, from joggers to exercise class students. Many of our programs will focus on health education classes in schools; others on personal fitness. We also welcome this opportunity to join with the Illinois State Medical Society in promoting the programs of its Sports Medicine Committee.

The ISMS Sports Medicine Committee is exploring a wide range of approaches to physician sports medicine education. "The tremendous increase in participation in athletic competition is mirrored in the rising number of sports related injuries. Treatment of such injuries has become part of the practice of countless primary care physicians as well as specialists," reports Peter Vinciguerra, M.D., chairman of the ISMS Council on Public Relations and Membership Services. To increase physician awareness of sports related injuries, it was recommended that the Sports Medicine Committee ask the Chicago Medical Society to include a half-day sports medicine seminar at their 1981 Midwest Clinical Conference.

Currently the ISMS Field Service Staff and the Trustees are attempting to identify educational programs available to coaches, trainers, and other non-physician personnel responsible for initial treatment of sports related injuries and also the physicians involved in sports medicine in each Illinois district.

ISMS will support efforts of the Governor's Council on Health and Fitness in development of mechanisms for requiring that high school athletic coaches document (1) cardiopulmonary resuscitation training and (2) continuing education in prevention and management of athletic injuries. With the Illinois Auxiliary's interest in CPR training, it seems natural that we assist the Sports Medicine Committee in furthering their sports medicine programs.

Let's not forget our personal involvement in physical fitness. A Harris poll of 1700 American adults last March revealed that Americans are exercising more—59% in 1979 as opposed to 24% in 1961. The survey classified 15% of the total sample as highly active, 16% moderately active, 28% less active, and 41% non-active. No significant differences in sleeping, dieting, and smoking patterns were found between active and non-active groups. However, active people claimed that their activity helped them feel less

tense, more relaxed, less tired, more disciplined and more productive. Active persons also reported that they enjoyed increased self confidence, a better self image, improved coordination, greater stamina, and positive psychological well being. Active people also reported fewer illnesses.

Obstacles to physical fitness include belief in such "exercise" myths as—middle aged and older people need no exercise other than walking; everyday activities are enough; physical fitness is a fad; and fitness is more what you eat than how much you exercise. Persons in the survey also cited insufficient time, sheer procrastination, lack of facilities and health reasons as factors not conducive to exercise. Interestingly enough, the one factor likely to have the greatest impact on increasing the number of active Americans is *a doctor's recommendation*.

As marathon runner Dr. Joan Ulyot of San Francisco says, "90% of the diseases physicians see are lifestyle diseases caused by smoking, over-eating, overdrinking, and being sedentary. People need to take greater responsibility for their lives." Perhaps both the doctor and the patient should take care . . . of themselves. A foot in the right direction might be the first step. ◀

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## EKG

(Continued from page 276)

**Answers:** 1. D.E. 2. D.

The resting ECG showed an old inferior lateral myocardial infarction. The Q waves from this infarction can be seen in leads 2 and V<sub>6</sub>. As exercise progressed, the ST segment elevated and the R wave became taller. These findings are best seen in lead 2 at 0 recovery in the last panel. He exercised for seven minutes by the Bruce protocol and had a maximal heart rate of 150 beats/minute and a maximal blood pressure of 180/110 mmHg. The patient stopped because of general fatigue, not angina. The test is abnormal because of ST segment displacement of more than 2mm and an increase in R wave amplitude. The Thallium myocardial scan showed a significant perfusion defect in the inferior wall at exercise which did not reverse in the rest scan. This was interpreted as irreversible myocardial ischemia in

keeping with the old inferior lateral infarction. A radionuclide measurement of left ventricular function demonstrated a large left ventricle, an ejection fraction of 23% and a possible ventricular aneurysm. The patient did not have any further coronary angiography. ST segment elevation in exercise is uncommon ranging from 2 to 6% of abnormal tests. It is mostly associated with severe coronary artery disease and left ventricular dysfunction, usually an aneurysm. Coronary artery spasm in the presence of significant fixed obstructions has also been suggested. Severe obstructions in the left anterior descending coronary artery as well as left ventricular aneurysms are often seen. For further reading see Chahine *et al.*, *Circulation* 54:209, 1976 and Longhurst *et al.*, *Circulation* 60:616, 1979. ◀





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# Viewbox

(Continued from page 274)

All of the choices can cause a unilateral hyperlucent lung. Only an endobronchial lesion of Swyer-James' syndrome would cause air trapping and the main bronchus in Figure 2 is normal.

*Swyer-James' Syndrome* is the end product of lung damage resulting from childhood pulmonary infection. Most often one lung is affected but a single lobe or lobes in both lungs may be involved. The most overt radiographic sign is hyperlucency of one lung. This sign is not specific since unilateral hyperlucency is found in many situations<sup>1</sup> including:

*Technical Causes:* Rotated patient, uncentered X-ray tube.

*Chest wall abnormalities:* Absent breast, muscle wasting, scoliosis.

*Lung Disease—Contralateral:* Pleural thickening, fibrosis, infection.

*Lung Disease—Ipsilateral:* Lobectomy, atelectasis with compensatory hyperexpansion, air-way lesion, bulla, Swyer-James', extrinsic bronchial compression.

*Vascular:* Hypoplastic pulmonary artery, pulmonary embolism, extrinsic narrowing of PA by neoplasm or inflammation.

Swyer-James' Syndrome may be discovered in an asymptomatic patient on the basis of a screening chest radiograph. Findings in addition to non-specific hyperlucency are: decreased peripheral vasculature, and air trapping (Figure 1).

The affected lung or lobe may be small or normal in size but air-trapping is consistently present in either case. A central, partially obstructing endobronchial lesion can also produce hyperlucency, air trapping, and decreased blood flow. The decreased blood flow with a "check-valve" endobronchial lesion is due to reflex vasoconstriction caused by hypoxia. Before the diagnosis of Swyer-James' Syndrome is made, an endobronchial lesion should be ruled out by bronchoscopy, tomograms, or bronchography.

Bronchography in Swyer-James' Syndrome is characteristic with dilated, abruptly ending, clubbed bronchi and lack of peripheral filling (Figure 2). Perfusion lung scans demonstrate decreased blood flow and there is decreased ventilation and evidence of gas-trapping with

ventilation scanning.<sup>2</sup>

Many patients have a past history of childhood respiratory infections, often viral bronchiolitis and often caused by an adenovirus. Parenchymal lung and small airway damage result in unilateral or lobar emphysema. Hypovascularity is a secondary effect. (The patient presented here had severe pneumonia at age 5.) Symptoms, when present, may not occur until adulthood.

Dyspnea on exertion is a common symptom. Pulmonary function studies are abnormal with decreased vital capacity, decreased ventilation on the abnormal side, and decreased mixing efficiency. ◀

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# REPORT

## FOR *Illinois Physicians*

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### EMERGENCY BENEFITS EXPLAINED

(Please Note: The Chicago-based Blue Cross and Blue Shield Plan has developed a booklet for its membership explaining the proper use of emergency benefits provided by the Plan. Because the information contained in the booklet may be of interest to you, we are including excerpts from it in the following report).

"Blue Cross and Blue Shield benefits cover the treatment of injuries resulting from accidents, attacks on your person, slips or falls—in brief any injury which requires prompt attention. These include . . . fractures of all types, sprains or strains, burns, cuts and any injury requiring immediate surgery.

#### **Follow-ups not covered**

"Benefits include Out-Patient or Emergency Department care and the services of the attending physician, provided treatment is received within 72 hours of the accident or injury. This applies only to the first treatment. Follow-up out-patient visits are not covered under emergency benefits. In those cases where a hospital stay is necessary, you will be covered for all charges eligible under your particular Blue Cross and Blue Shield program.

"Since accidents can occur anywhere at any time, it's good to know that your Blue Cross and Blue Shield membership card quickly identifies you to hospitals and doctors throughout the country. Always carry it with you when you travel.

"Benefits are provided for medical emergencies when symptoms are severe enough to endanger life or bodily functions unless the patient receives prompt treatment. The following conditions are examples of true

medical emergencies . . . sudden chest and arm pains severe enough to indicate a possible heart attack, severe bleeding of any kind, including vomiting of blood, sudden inability to move arms or legs, severe allergic reactions and attacks of dizziness severe enough to cause staggering.

#### **First treatment eligible**

"In cases such as those listed above . . . benefits are provided for the first treatment whether received in the Emergency Department or Out-Patient Department of a hospital or clinic, or in the doctor's office. Treatment should be received immediately for symptoms severe enough to require emergency care. As is the case with injuries, only the first treatment is eligible for emergency benefits. If a hospital stay should be necessary after your condition is diagnosed, you will, of course, be covered for all services eligible under your particular Blue Cross and Blue Shield program.

When you use emergency facilities simply for convenience—because you can't get a doctor's appointment or because the Emergency Department is such a handy place to have your blood pressure checked—be prepared to pay for the service yourself. On the other hand, you can count on Blue Cross and Blue Shield benefits to take care of true emergencies wherever treatment is received—in a hospital facility, an approved surgical center or clinic, or in the doctor's office.

"Note: Patients having Major Medical coverage in addition to their basic Blue Cross and Blue Shield program may receive benefits for follow-up care after the Major Medical deductible has been met."

# COB SYSTEM SAVES TIME AND MONEY

When a person is covered by more than one health insurance carrier, it's beneficial to all concerned if these carriers share financial responsibility for payment of that person's health care claims. This is called Coordination of Benefits or COB.

Coordination of Benefits has become an important part of the health insurance business within the past 5-10 years, due mainly to the increasing number of working wives who are covered by group contracts at their own place of business, in addition to being covered under their husband's policies.

COB is also an important cost containment measure. Sharing payments allows each carrier involved to pay out less money, which amounts to a sizable savings and keeps premiums down.

When more than one carrier is involved, one is determined to be the primary carrier and one is the secondary carrier, provided they both have COB provisions.

## Subscriber's carrier primary

When the patient is the subscriber, that carrier is primary. When the patient is the dependent child of a male subscriber, that carrier is primary. Where the patient is the dependent of the female subscriber, that carrier is secondary if the patient is also the dependent child of a male subscriber. If the patient is the subscriber under two contracts, the one in effect the longest assumes primary responsibility. However, if one carrier has a COB provision and the other doesn't, the non-COB coverage is automatically primary, regardless of the relationship of the patient to subscriber.

The carrier having primary liability pays the full amount of its regular responsibility for that claim. The secondary carrier is only responsible for unpaid balances of eligible charges, up to the extent of what it would pay if it were the primary carrier.

Naturally, it is in a carrier's best interest to institute a COB program, because in many instances that carrier might be secondary and need to pay out a smaller portion of the amount it would pay if it were the primary or sole carrier.

The Chicago-based Blue Cross and Blue Shield Plan began instituting COB procedures quite a few years ago, and in January 1977, a separate COB department was established. The COB system, however, was manual. It had to rely heavily on information from the provider (hospital forms ask whether or not the patient has other coverage), and it had no way of storing this information. If a patient re-entered the hospital, COB again had to rely on provider information. Obviously, this system was very difficult to maintain, and contacting a subscriber to check on duplicate coverage could be quite costly and time-consuming.

## System Automated

Fortunately in December 1978, the Plan began converting its accounts to a new automated computer COB system. The benefits are tremendous and the savings are substantial. One of the key features of the new automated system is the maintenance of a COB data base which helps resolve information retention problems.

The more information the Plan has the more money it can save if it determines that it's the secondary carrier. COB potential (and cost containment impact) is quite substantial.

Not only does the Plan save money, but groups can save money too, because the rate of experience is reduced and the rate of premium increase also may be reduced.

### Mail Hot-Line—

Are you using the services of Blue Shield's telephone and mail hot-lines? They were established for the special use of providers of professional services, their office assistants and billing agencies.

This service is being offered for your convenience to handle only provided inquiries. The toll-free number to call is 800-972-8088 from 8:30 A.M. to 4:30 P.M. *Please do not give this number to your patients.*





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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

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Clinical Practice

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# Clinics For Crippled Children Listed For July

Thirty-eight clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, nine cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Quincy—St. Mary's Hospital
- 1 Danville—Lake View Hospital
- 1 Park Ridge Cardiac (a.m.) Lutheran General Hospital
- 1 Park Ridge General (p.m.) Lutheran General Hospital
- 2 Wheaton—Marianjoy Rehab. Hospital
- 2 Hinsdale—Hinsdale Sanitarium
- 3 Sterling—Community General Hospital
- 3 Lake County Cardiac—Victory Memorial Hospital
- 8 East St. Louis—Community Hospital
- 8 Peoria General—St. Francis Hospital
- 8 DuQuoin—Marshall Browning Hosp.
- 9 Champaign-Urbana—McKinley Hospital
- 9 Joliet—St. Joseph's Hospital
- 9 Chicago Heights General—St. James Hosp.
- 10 Springfield General—St. John's Hospital
- 10 Macomb—Medical Bldg. of McDonough District Hospital
- 10 Aurora General—Mercy Center for Health Care Services
- 11 Division Cardiac—U. of I. at the Medical Center
- 14 Peoria Cardiac—St. Francis Hospital
- 14 Chicago Heights Cardiac—St. James Hosp.
- 15 Belleville—St. Elizabeth's Hospital
- 15 Rock Island Area General—Moline Public Hospital
- 15 Decatur—Decatur Memorial Hospital
- 15 Maywood—Loyola Medical Center
- 16 Evergreen Park—Little Co. of Mary Hosp.
- 17 Effingham—St. Anthony Memorial Hosp.
- 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 18 Kankakee Cardiac—St. Mary's Hospital
- 22 Peoria General—St. Francis Hospital
- 22 Maywood General—(half-day, ortho only) Loyola Medical Center
- 23 Rockford—St. Anthony's Hospital
- 23 Chicago Heights General—St. James Hosp.
- 23 Elgin General—Sherman Hospital
- 24 Centralia—St. Mary's Hospital
- 28 Peoria Cardiac—St. Francis Hospital
- 28 Chicago Heights Cardiac—St. James Hosp.
- 29 Alton—Alton Memorial Hospital
- 30 Springfield Ped-Neuro—St. John's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## Librax®

Each capsule contains 5 mg chlorthalidone HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlorthalidone HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librax® (chlorthalidone HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlorthalidone HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlorthalidone HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

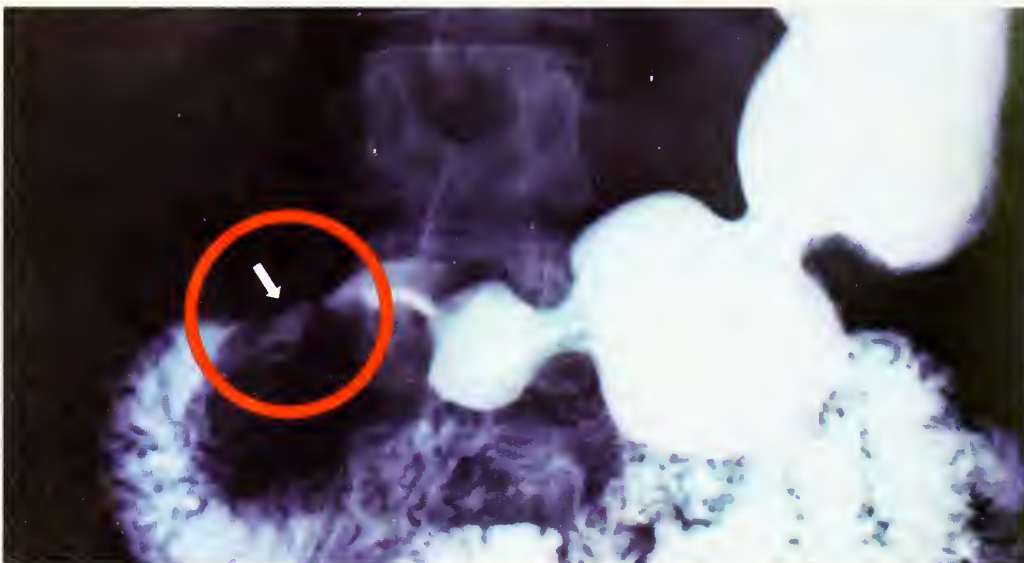
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# The stress-secretion relationship in duodenal ulcer\*



The pituitary gland plays a key role in the neurohormonal response to emotional stress, leading to an increase in gastric secretion.<sup>2</sup>



The duodenal ulcer reflects the erosion of a vulnerable mucosa by acid-pepsin secretion.<sup>2</sup>

The best available evidence<sup>1,2</sup> suggests that chronic anxiety stimulates acid-pepsin secretion. Also, the development of an ulcer crater in predisposed individuals, or the aggravation of ulcer symptoms, is often associated with a stressful event or situation.<sup>1</sup> Thus, anxiety seems to play an important role in the course and prognosis of the disease.<sup>1</sup>

To obtain more comprehensive relief, many duodenal ulcer patients need more than specific, acid-inhibiting medication. They also need reduc-

tion of accompanying anxiety and emotional tension.

**References:** 1. Isenberg J, Richardson CT, Fordtran JS: Pathogenesis of peptic ulcer, chap. 46, in *Gastrointestinal Disease*, ed. 2, edited by Sleisenger

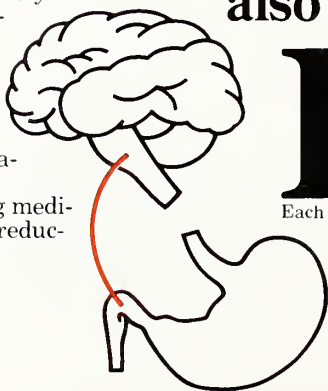
MH, Fordtran JS, Philadelphia, WB Saunders Company, 1978, vol. 1, pp. 800-801. 2. Sun DCH: Etiology and pathology of peptic ulcer, chap. 27, in *Gastroenterology*, ed. 3, edited by Bockus HL, et al, Philadelphia, WB Saunders Company, 1974, pp. 579-595.

## More than an antisecretory agent... also acts on accompanying anxiety

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### antianxiety/antisecretory/antispasmodic



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\*Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on preceding page.



# Abstracts of Action

April 12-16, 1980

Chicago

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## MEDICAID

As a result of negotiations with ISMS, IDPA has agreed to inject medical judgment into the Medicaid audit process. Under the new system, physicians will be granted the right to have physicians peer review audit determinations concerning the level of care reflected in patient records. ISMS will recruit physicians who will perform the review under contract with IDPA. Initially, the program will be conducted on a limited basis to ensure smooth implementation. In other Medicaid-related actions, the Board voted to:

- Stress to Gov. Thompson the need to increase physicians' Medicaid fees in order to maintain the availability of high quality care to the indigent.
- Urge IDPA to acknowledge receipt of physician bills. IDPA rules require that bills must be submitted within six months after the service is rendered. Under the current system, a physician may attribute his lack of reimbursement to a processing delay, not realizing—until after the deadline—that IDPA either has not reviewed or lost the claim.

ISMS will publicize Illinois physicians' monetary contribution—the difference between amount billed and paid—to the state's Medicaid program.

## LEGISLATION

During the current General Assembly session, ISMS will oppose legislation that would: (1) Permit pharmacists to practice drug product selection unless a physician indicates on the prescription blank that drug substitution is prohibited; and (2) Require psychotherapists—who determine that a patient may present a danger to a third party—to notify the third party of that possible danger.

ISMS "will not oppose" proposed legislation—labeled the Medical Student Grant Act—that would require students accepting state grants to practice in Illinois upon graduation. The Illinois Osteopathic Association may seek introduction of the proposal in the current General Assembly session.

## HEALTH PLANNING

ISMS will oppose "institution specific" appropriateness review by health planning agencies. Under the federal planning law, an HSA's review can focus on areawide institutional health services or zero-in on specific hospitals. Under the "institution specific" approach, the HSA could declare a hospital—or one of its clinical services "inappropriate." The law does not prescribe sanctions in such cases, but the HSA's ruling could result in denial of third party reimbursement, liability problems and other threats to a hospital's financial stability and reputation. ISMS will assist physicians—who are active in health planning—in opposing "institution specific" review, and ISMS trustees will monitor HSA activities to ensure adequate medical input into their appropriateness review activities.

## PUBLIC HEALTH

ISMS will urge IDPH to continue its Rheumatic Fever Prophylaxis Program for those patients who are economically unable to purchase needed medication. The program's federal funding has been cut back, and IDPH has not budgeted funds to support it during fiscal 1981.

(Continued on page 379)



# ANUSOL-HC

SUPPOSITORIES/CREAM WITH HYDROCORTISONE ACETATE

#1 prescribed hemorrhoidal product

IT WAS  
NUMBER ONE  
IN 1959

AND IT STILL IS...

The professional source of  
modern anorectal comfort

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Hemorrhoidal Suppositories

## ANUSOL-HC<sup>®</sup> CREAM

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**Caution:** Federal law prohibits dispensing without prescription.

**Description:** Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

**Indications:** Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol<sup>®</sup> Suppositories or Ointment.

**Contraindications:** Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

**Warnings:** The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

**Precautions:** Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

**Dosage and Administration:** Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

**Anusol-HC Cream — Adults:** After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

**NOTE:** If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

**How Supplied:** Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C). Full information is available on request.

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00022 PD-JA-0234-I-P

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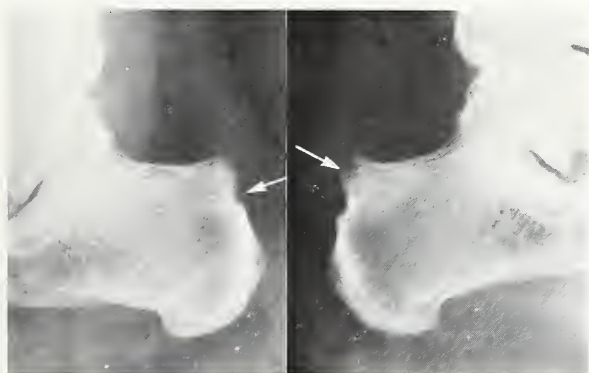
2/80



# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This 55 year old man has a long history of polyarthritis. He has peripheral lymphadenopathy, splenomegaly, and leukopenia with neutropenia.*



**Figure 1**  
Right and left calcaneus



**Figure 2**  
Shoulder

## ***What's your diagnosis?***

- (1) Reiter's syndrome
- (2) Rheumatoid arthritis
- (3) Felty's syndrome
- (4) Ankylosing spondylitis
- (5) Lipoid dermatoarthritis

*(Continued on page 388)*

# "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

June 23	Christ Hospital & A.C.S.	Oak Lawn
June 23	Blessing Hospital & A.C.S.	Quincy
June 23	Oak Park Lighted Schoolhouse Recreation Dept. & A.C.S.	Oak Park
July 7	Community Hospital & A.C.S.	Geneva
July 14	Anchor & A.C.S.	Chicago
July 29	Lutheran General Hospital	Park Ridge
September 15	Christ Hospital	Oak Lawn
October 6	Lake Forest Hospital & A.C.S.	Lake Forest
October 13	St. Mary's Hospital	Quincy
October 28	Lutheran General Hospital & A.C.S.	Park Ridge
November 17	Christ Hospital & A.C.S.	Oak Lawn
December 1	Anchor & A.C.S.	Chicago

- provides effective symptomatic relief
- b.i.d. dosage simplifies therapy
- scored tablet for dosage flexibility

## OPTIMINE®

azatadine maleate, 1 mg. tablets

**CONTRAINDICATIONS** Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

**WARNINGS** Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer, pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure, hyperthyroidism; cardiovascular disease, hypertension.

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined:

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

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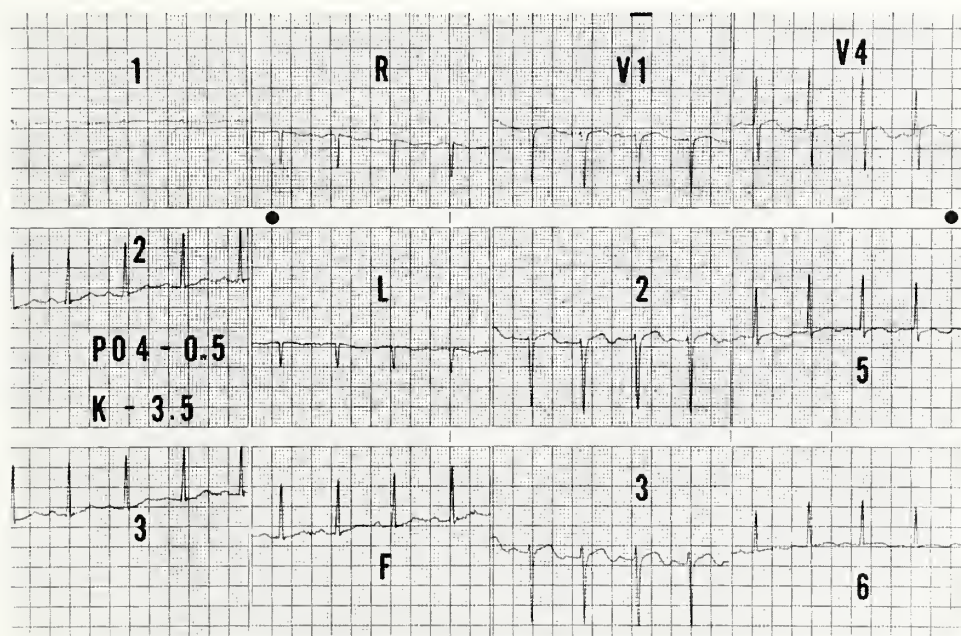
SWW-4171



# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a known insulin-dependent diabetic man who was doing well until two days before admission to the hospital. He was involved in a prolonged celebration which included excessive alcohol intake. Nausea, vomiting and anorexia followed and he failed to take his seventy units of NPH insulin. The next day he became confused and then comatose. In the emergency room, he had a blood pressure of 88/68 mmHg, a pulse of 120 beats/minute, and a respiratory rate of 42 per minute with Kussmaul breathing. He was dehydrated but the rest of the physical examination was normal. His blood work demonstrated a blood glucose of 866 mg/dl, serum ketones 160 mg/dl, BUN 69 mg/dl, sodium 131 mEq/l, potassium 5.1 mEq/l, chloride 94 mEq/l, and carbon dioxide content 5 mEq/l. Treatment for his diabetic ketoacidosis in the first fourteen hours included 120 units of regular insulin, 4.5 liters of normal saline, 176 mEq of sodium bicarbonate, and 230 mEq of potassium chloride. During this time his vital signs returned to normal. In addition, his blood glucose fell to 99 mg/dl, potassium decreased to 3.5 mEq/l, and carbon dioxide content increased to 17 mEq/l. His BUN fell from 69 to 34 mg/dl, plasma ketones and blood ethanol were undetectable. Despite clearing of his acidosis and restoration of his glucose level to normal, the patient did not regain consciousness. Instead, he showed increasing evidence of neuromuscular irritability with generalized twitching, hyperreflexia, and sustained ankle clonus. This ECG was taken at that time.



## Questions:

1. The twelve lead ECG shows:
  - A. An acute myocardial infarction.
  - B. Severe left ventricular hypertrophy.
  - C. Non-specific or non-diagnostic ST-T wave changes.
  - D. Prominent inverted U waves.
  - E. None of the above.
2. Which of the following statement(s) is (are) true?
  - A. Severe hypophosphatemia is most of-

- ten observed in chronic alcoholics, patients recovering from diabetic ketoacidosis, and patients being therapeutically refeed with hyperalimentation.
- B. Severe hypophosphatemia can cause a metabolic encephalopathy.
- C. Severe hypophosphatemia has also caused a reversible congestive cardiomyopathy.
- D. All of the above.

(Continued on page 394)

# Illinois Housestaff News

## Fourth Annual AMA-RPS Meeting

July 18 and 19, residents from throughout the country will gather for the fourth annual AMA-RPS meeting. Small group workshops on Friday, July 18, will deal with negotiations, skills and practice management in the morning and resident contracts and due process procedures in the afternoon.

The formal business meeting of the AMA-RPS will take place Saturday, July 19, following reports on national AMA activities and a complimentary luncheon.

The meeting schedule is available from the AMA Department of House Staff Affairs. Illinois resident physicians are welcome to attend all sessions.

### **Legislative Highlights: Abortion Complications Must Be Reported**

Illinois Law (P.A. 81-1161) requires a physician diagnosing abortion complications to report the diagnosis and a summary of physical symptoms to the Illinois Department of Public Health. A reporting physician must also identify where the abortion was performed, if possible.

Since resident physicians often may be covering emergency rooms to which patients suffering abortion complications may come, we should be aware of this legislation and determine that such complications are properly reported. A violation of this legal duty can result in revocation of a physician's medical license.

### **Variable Incentive Pay Includes "Obligated Physicians"**

The U.S. House and Senate have finally resolved differences in bills concerning Variable Incentive Pay for military physicians. The Special Pay Act of 1980 brings good news to young physicians fulfilling service obligations to Army, Navy, Marines, Air Force, or Public Health Service. "Obligated service" is not differentiated from other military or PHS service duty for the purposes of Variable Incentive Pay. Physicians ob-

ligated for service under military or Health Professions Scholarship programs will be eligible for the same incentive pay as are non-obligated physicians. The RPS and AMA have been actively involved in this legislation which eliminates pay discrimination against resident physicians who have incurred service obligations.

*\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.*

## **CHIEF RADIOLOGIST NEEDED BY OCTOBER, 1980**

**St. James Hospital**

**Chicago Heights, Illinois 60411**

**A 440 bed hospital and  
Trauma Center**

**Department of Radiology**

**Recently remodeled  
and re-equipped**

**CT Scan and Ultra Sound**

***Please send inquiry to  
S.A. Dekowski, M.D.,  
President, Medical Staff***



# Guest Editorial

## FTC Broadens Its Front In Attack On Medicine

To what degree will the Federal Trade Commission (FTC) be able to encroach on our medical professionalism and the public-spirited responsibilities that go with it?

This question loomed when the FTC challenged the AMA's ethical ban on physician solicitation of patients. It also is looming again on the issue of the FTC and medical-school accreditation, an issue that had been in abeyance during a two-year grace period.

At this writing the advisory committee to the U.S. Commissioner of Education was scheduled to open a hearing April 21 on the FTC's petition to dislodge the Liaison Committee on Medical Education (LCME) as accrediting body for medical schools.

As cosponsor of the LCME—along with the Association of American Medical Colleges (AAMC)—the AMA is again the prime target of the FTC action, just as in the ongoing case on physician advertising and solicitation.

FTC lawyers exultantly smell a rat in the AMA's accreditation role. They contend the Association wants to limit the number of schools and graduates for the same basic reason it allegedly wants to limit the scope of advertising: to stifle intraprofessional competition.

The contention is out of touch with the facts, of course. Instead of being held down, the number of approved medical schools has surged (with full AMA support) from 85 in 1960 to 126 today. Enrollment in that time has more than doubled.

Well, the FTC counters, the LCME just might sometime restrict the school growth.

Another federal agency—HEW—foresees no restriction. In a recent report, HEW stated: "Our nation's schools are currently geared to produce doctors at a rate that should put the total number in balance with our national needs by the 1980s. By the 1990s, we should have a supply greater than we will need."

In its move on accreditation, the FTC is joined by such "public interest" groups as Common Cause and Sidney Wolfe's Public Citizen Health Research Group. But we feel it's clearly in the public interest that the AMA continues waging arduous if costly battles to keep medical professionalism intact.

**American Medical  
Association**

**Formal Decision Regarding Discipline  
Of Medical Professionals  
Ordered by the State of Illinois  
Department of Registration and Education**

This report includes formal decisions regarding issuance, refusal to issue, restoration, renewal or refusal to renew, revocation and suspension of licenses and probationary or other disciplinary action taken by the Department. It does not include formal decisions involved in the Director's approval of board or committee recommendations to issue licenses to persons passing licensure examinations.

MEDICAL PROFESSION

FORMAL DECISIONS REGARDING DISCIPLINE  
ORDERED BY THE DEPARTMENT OF REGISTRATION AND EDUCATION

<b>Name &amp; Address Profession</b>	<b>Act (Ill. Rev. Stat.) &amp; Section And/Or Rule Violated</b>	<b>Discipline Ordered Case Number</b>	<b>Date Ordered</b>
Robert Underwood 129 South Bethalto Drive Bethalto, Illinois 62910 MEDICAL DOCTOR 36-36119	Chpt. 111, Sec. 4433 Allegations that respondent was addicted to Demerol, and obtained narcotics by fraud and deceit.	Revocation Controlled Substances License; One Year Suspension Medical License; and Psychiatric Treatment. From 3-1-80 to 2-28-81, if he obtains a favorable psychiatric evaluation. Consent Order 79-102	1-10-80
Andrew Adams 401 North Wall Street Kankakee, Illinois 60901 MEDICAL DOCTOR 36-35707 003-035707	Chpt. 111, Sec. 4433 Respondent acknowledges that he has used alcohol and narcotics for non- therapeutic purposes.	30 Day Suspension Medical License; Voluntary Surrender of Schedule II & III Controlled Substances License; and Indefinite, Voluntary Suspension of Schedule II, III, IV & V Controlled Substances License Consent Order 79-185	2-7-80
Bruce F. Avery 105 North Avon Rockford, Illinois 61101 MEDICAL DOCTOR 36-24507	Chpt. 111, Sec. 4433 (2) Respondent was convicted in Circuit Court of Winnebago County of delivery of a controlled substance.	Revocation 79-110	2-1-80
Stephen O. Mallinga 2639A South Michigan Ave Chicago, Illinois 60616 MEDICAL DOCTOR 36-52607	Chpt. 111, Sec. 4433 (1) (4), (22) and (24) Respondent was employed to perform and did perform elective abortions at Summit Clinic, a facility later determined by the Department to have been unlicensed to provide such services.	Seven (7) Day Suspension Consent Order 79-49	2-1-80



Name & Address Profession	Act (Ill. Rev Stat.) & Section And/Or Rule Violated	Discipline Ordered Case Number	Date Ordered
Godwin O. Onyema 3041 South Michigan Chicago, Illinois 60616 MEDICAL DOCTOR 36-54176	Chpt. 111, Sec. 4433 (1) (4), (22), & (24) Respondent was employed to perform and did perform elective abortions at Summit Clinic, a facility later determined by the Department to have been unlicensed to provide such services.	Seven (7) Day Suspension Consent Order 79-47	2-1-80
Kambhatla Ramachandar 4 Consulate Drive Tuckahoe, New York 10707 MEDICAL DOCTOR 36-45333	Chpt. 111, Sec. 4433 (4) (11) Respondent's license to practice medicine in the State of California was revoked.	Indefinite Suspension 79-147	2-20-80
Adrian Russell 1580 Sherman Avenue Evanston, Illinois 60201 MEDICAL DOCTOR 36-30152	Chpt. 111, Sec. 4433 Respondent prescribed the drug Quaalude in combination with other depressants and for periods of time longer than the recommended regimen.	One (1) Month Suspension Schedule II Controlled Substances License Consent Order 80-22	2-25-80
Swie-Liang Tan 1558 West 79th St. Chicago, Illinois 60620 MEDICAL DOCTOR 36-47108	Chpt. 111, Sec. 4433(4) His treatments of obese patients did not meet professional standards.	One Year Probation Consent Order 80-13	2-28-80

## Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

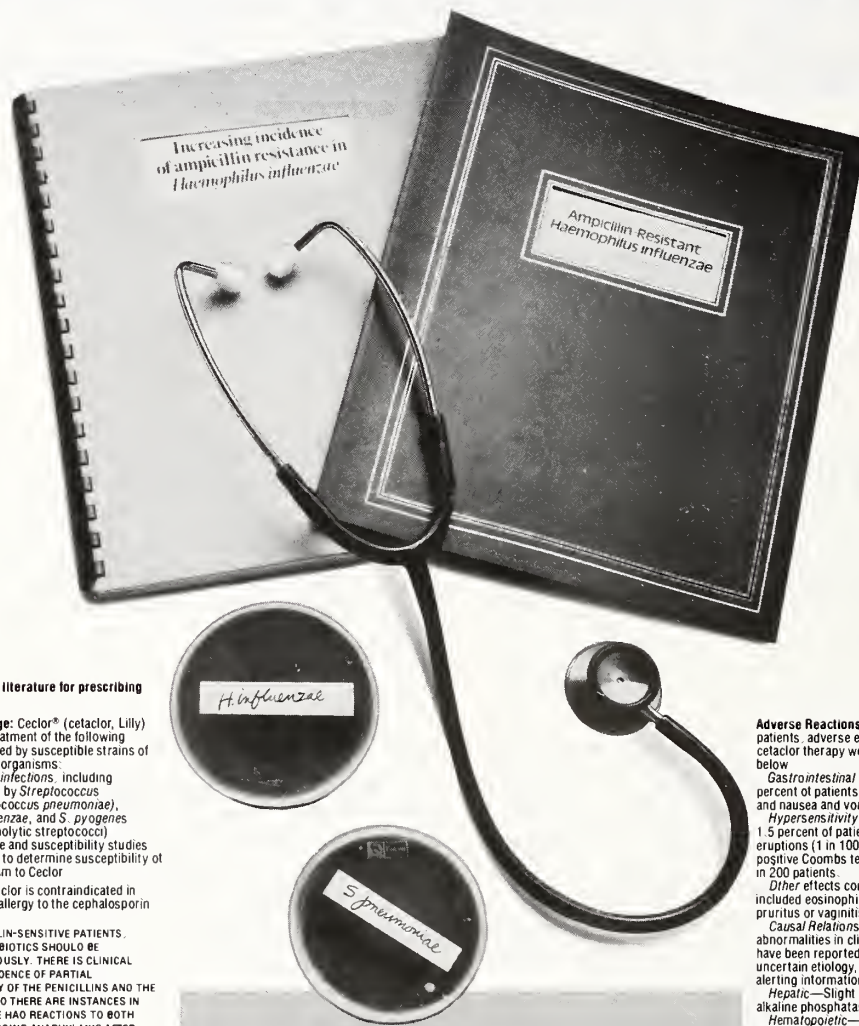
References should be numbered in order of appearance in the text and conform to the fol-

lowing style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.

# An added complication... in the treatment of bacterial bronchitis\*



## Brief Summary Consult the package literature for prescribing information.

**Indications and Usage:** Cefaclor\* (ceftacil, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections,** including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

**Contraindication:** Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

**Usage in Pregnancy:**—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy:**—Safety of this product for use in infants less than one month of age has not been established.

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefaclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.<sup>7</sup>

# Cefaclor®

## cefaclor

Pulvules®, 250 and 500 mg

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

**Gastrointestinal symptoms** occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

**Hypersensitivity reactions** were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

**Other effects** considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain:**—Transient abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic:**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic:**—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal:**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

\* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

**Note:** Cefaclor\* (ceftacil) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

## References

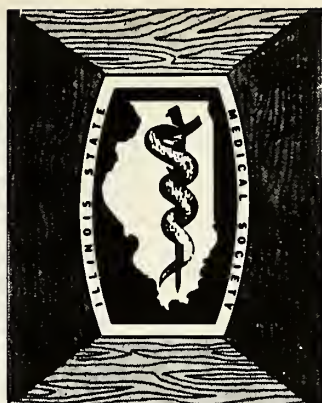
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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630



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# I M J

Illinois Medical Journal

Vol. 157, No. 6, June, 1980

## Evaluation of the Obstructed Esophagus

BEN J. DOLIN, M.D./PEORIA

*The esophagus is a muscular tube which functions as a conduit for food to pass from the oropharynx to the stomach. As long as the esophagus provides a satisfactory passage, there will be no alteration of body function. It is not surprising that symptoms of esophageal disease relate to an interruption of the smooth process by which the food passes from the oropharynx to stomach. The patient who experiences difficulty with this orderly process is by no means rare. Unfortunately, he may not seek help until the abnormality is far advanced or in some instances, the physician may fail to recognize symptoms of esophageal dysfunction and thereby delay diagnostic evaluation and the initiation of proper treatment.*

Dysphagia is the most important symptom of esophageal obstruction from either a mechanical or motility disorder. Dysphagia is a subjective feeling that something has interfered with the smooth passage of a solid or liquid bolus. The patient will say that food "sticks," "hangs up," or "just won't go down." The sensation of dysphagia occurs within ten seconds of the swallowing act. Dysphagia is never a manifestation of hysteria or other emotional disorder and its

presence demands thorough clinical investigation. The sensation of a lump in the throat which is not related to swallowing is referred to as "globus hystericus." The clinician must be precise and certain of his clinical assessment before deciding upon this latter diagnosis.

The type of food which causes the dysphagia frequently will give a clue to its etiology. When there is a lesion causing a mechanical obstruction, such as stricture or tumor, dysphagia initially will be experienced only with the ingestion of solid food such as meat, fruit or bread. The lumen must be narrowed by almost 50% to regularly cause dysphagia to solid food. As the mechanical obstruction becomes more severe, dysphagia will be experienced with softer foods and eventually with liquids. It is not uncommon for a patient to present who can swallow only "baby food." Motor disorders of the esophagus may cause dysphagia without regard to the type of food.

BEN J. DOLIN, M.D., is a board certified internist and gastroenterologist who serves as an instructor of the UI Peoria School of Medicine. Dr. Dolin is affiliated with the Methodist Medical Center in Peoria.



negative barium swallow does not rule out mechanical or neuromotor disorders and patients with persistent symptoms should be evaluated by other means.

### Endoscopy

With the introduction of flexible fiberoptics, endoscopic examination of the esophagus has become quick, simple, safe and highly accurate for most diseases. Endoscopic evaluation is especially good to evaluate luminal narrowing and differentiate benign and malignant disease. It is also helpful in evaluation of certain motility disorders, such as achalasia.

Once the endoscope is in the lumen of the esophagus, it is advanced slowly while the walls of the esophagus are examined. If the lumen is narrowed to, or less than the endoscope diameter, the instrument will not easily pass and a rough estimate of the size of the narrowing may be made. If, however, the lumen is narrowed but still larger than the endoscope diameter, the endoscopist may fail to recognize a stenotic area. In addition, the direction of the distal lumen in relation to the more proximal esophagus can be estimated. The size of the opening and the direction of the lumen, the color of the mucosa and its surface characteristics are noted. Benign reflux strictures may show changes which vary from mild mucosal erythema to a friable, ulcerated mucosa with overlying exudate. Benign proximal or midesophageal strictures usually are associated with a columnar lined lower esophagus known as Barrett's esophagus.

When a malignant esophageal lesion is suspected, endoscopic evaluation permits a precise histologic diagnosis by cytology and/or biopsy and allows accurate determination of tumor location and extent. The ability to take small mucosal biopsies and brush cytology has produced a diagnostic accuracy of almost 100%.<sup>6</sup> The amount of luminal narrowing can be evaluated, as well as the direction of the lumen and this will help to plan the future dilation treatment (Figure 3).

Endoscopy in motility disorders of the esophagus is indicated to confirm the diagnosis, and more specifically in achalasia, to determine the anatomic status of the lower esophageal area that will be dilated. In severe achalasia, the esophagus will be patulous and without noticeable peristalsis. In the area above the lower esophageal sphincter, there is tapering of the longitudinal folds and there may be mild esophagitis due to retained food. Although food does not readily pass from esophagus to stomach,



**Figure 3**  
Endoscopic photograph of malignant ulcer in distal esophagus. Same patient as in Figure 2.

the endoscope is advanced with only mild to moderate difficulty through the sphincter into the stomach. With the new flexible fiberoptics, it is important to retroflex the tip to view the gastric side of the gastroesophageal junction and rule out pathology in the gastric cardia.

### Esophageal Motility

In the last few years, esophageal motility has emerged from the physiology laboratory to play a definite but limited role in clinical medicine. It has been recommended that motility tracings be limited to three conditions: (1) preoperative evaluation of patients with reflux, (2) evaluating chest pain and (3) achalasia.<sup>7</sup> In patients with reflux, a motility study is done to evaluate lower esophageal sphincter pressure and to search for other motor disorders which may have caused the problem. Decreased pressure in the lower esophageal sphincter is felt to correlate with a poor response to medical therapy. Chest pain and sometimes dysphagia may be produced by diffuse esophageal spasm. If spasm occurs or can be provoked during the motility study, the symptoms can be correlated very well with abnormal esophageal pressure.

Esophageal motility is most useful in the evalu-



ation of suspected achalasia. It is not uncommon for the clinical and X-ray features to be strongly suggestive of achalasia but the condition cannot be confirmed without the appropriate manometric findings. Achalasia is usually manifested by an elevated resting lower esophageal sphincter pressure, and after swallowing the sphincter fails to relax completely.

### Summary

Once a patient presents to his physician with symptoms of esophageal obstruction, a combination of detailed history, radiography, endoscopy and occasionally esophageal motility, will provide a diagnosis. These methods of investigation will allow the physician to plan a course of therapy to relieve the obstruction. Therapy usually includes esophageal dilation. Surgical therapy is rarely needed for benign lesions and is not often helpful for malignant obstruction. It is important, however, that the symptom of dysphagia be thoroughly investigated and not ever passed off as an hysterical or "functional" complaint. ◀

### Acknowledgement

The author wishes to express his appreciation to Mrs. Betty J. Page for expert secretarial assistance.

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## Correction

The patient presented in the Viewbox of the May issue (page 274) had the Swyer-James' Syndrome. She did not have dextrocardia—the PA chest film was printed backwards and is presented correctly at left.

Confusion in paragraph one of the discussion (May issue, page 316) was due to a printers' error. Two of the diagnostic choices given can result in a hyperlucent lung plus air trapping: Swyer-James' or an endobronchial lesion. The bronchogram demonstrates the characteristic clubbing of bronchi and lack of distal filling seen in Swyer-James'. The normal, proximal bronchi exclude an endobronchial lesion.

We apologize.

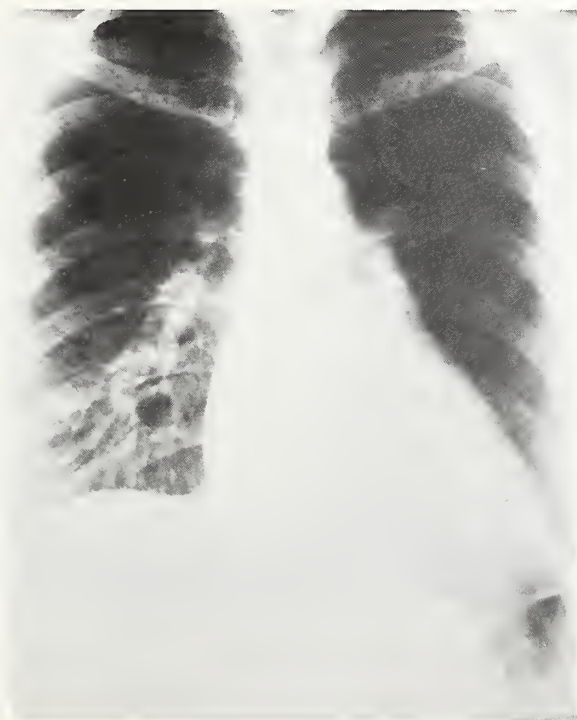


Photo PA Chest  
May, 1980, Viewbox Case of the Month

# Case Reports

## Erythroplasia of Queyrat Involving the Distal Urethra

BY PAUL W. WAVAK, M.D., ELVIN G. ZOOK, M.D. AND WILLIAM S. WHITE, M.D.  
SPRINGFIELD

*Erythroplasia of Queyrat is a precancerous lesion which classically involves the glans and prepuce and sometimes the shaft of the penis but, to our knowledge, has not been reported to involve the distal penile urethra. Two cases are presented in which this involvement occurred and the treatment of these lesions is outlined.*

Erythroplasia of Queyrat is a carcinoma *in situ* or a precancerous lesion which usually involves the glans of the penis and sometimes the prepuce but rarely the skin of the penis. This lesion is confined for the most part to the mucosal surfaces and is occasionally seen in females in the area of the labia minora and majora.

Involvement of the urethra with

this process, to our knowledge, is unreported. In this paper we shall present two patients in which this involvement occurred.

### Case Report #1

On initial interview, patient history included a lesion on the shaft of his penis which had been excised three years previously with a diagnosis of Bowen's disease. He was without recurrence of disease for several months but then developed a lesion on the glans of his penis. It was felt that maceration contributed to his problem and a circumcision was performed. The involved area on his glans did not improve. A biopsy was performed and reported as Erythroplasia of Queyrat. On our initial examination he was found to have involvement of the glans of the penis along approximately half of the dorsal and ventral surface extending from the corona to the urethral meatus. (Figure 1-2) One month later he had excision of the involved area on the glans penis with frozen section control of the margin and split thickness skin grafting of the defect which healed without complications. (Figure 3) Nine months after surgery, he developed another

lesion approximately two millimeters in diameter at the urethral meatus. This was biopsied and found to be Erythroplasia of Queyrat.

The patient was returned to the operating room and a circumferential excision around the urethra at the meatus was performed extending several millimeters into the urethra. Frozen sections of the urethral margin, however, revealed this to be involved with carcinoma *in situ*. In order to gain access to the urethra a meatotomy incision was made. A grossly normal appearing urethra was found but further sections of the urethra revealed carcinoma *in situ* extending proximally about 2½ cms. The involved urethra was excised. (Figure 4) It was felt that reconstruction of the urethra should be delayed and, as a consequence, the proximal urethra was exteriorized to the ventral side of the penis and the distal shaft and glans was closed primarily. The patient is being followed with periodic cystoscopic examinations and has no evidence of recurrence. (Figure 5)

### Case Report #2

A 44 year old white male had

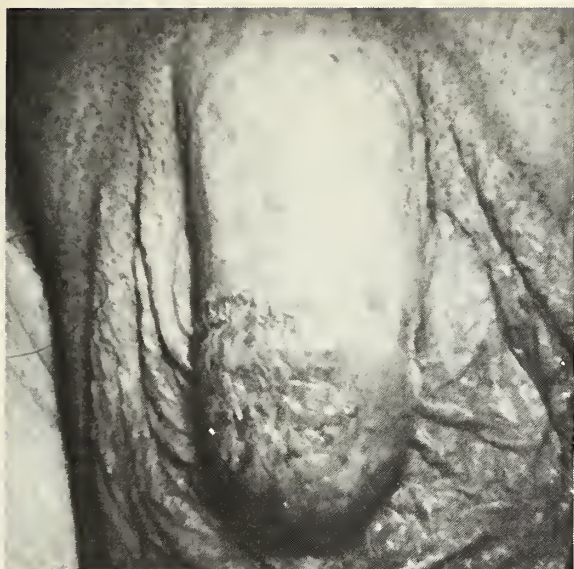
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PAUL W. WAVAK, M.D., is a board certified plastic and reconstructive surgeon and chief of the department of plastic surgery at St. John's Hospital in Springfield. Dr. Wavak also serves as a clinical assistant professor in the SIU School of Medicine Division of plastic surgery.

ELVIN G. ZOOK, M.D., is director for the Congenital Head and Neck Anomalies Clinic at the SIU School of Medicine in Springfield. A diplomate of the American Boards of Surgery, Thoracic Surgery and Plastic Surgery, Dr. Zook is former president and chairman of the SIU School of Medicine Faculty.

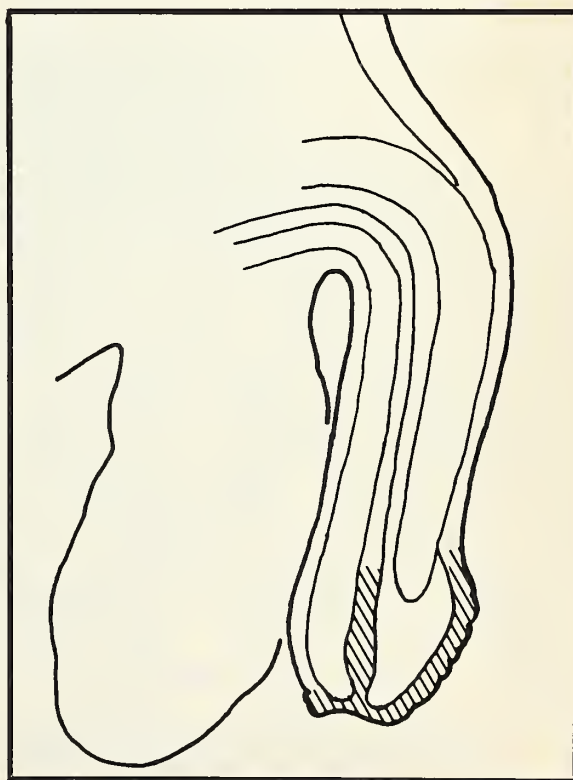
WILLIAM S. WHITE, M.D., was a clinical associate professor in the SIU School of Medicine Division of Urology at this writing. Dr. White is now deceased.





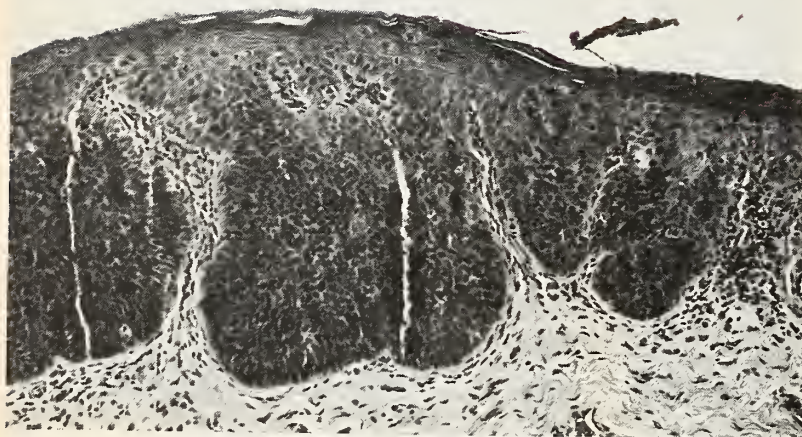
**Figures 1 and 2**

Figure 1 (left) shows Case 1, dorsal surface of the glans preoperatively. Figure 2 (right) shows Case 1 ventral surface of the glans preoperatively.



**Figures 3 and 4**

Figure 3 (above) shows dorsal surface of glans post skin grafting. Figure 4 (right) shows schematic drawing of involvement of the glans and urethra.



**Figure 5**

**Case 1: Typical area through involved urethra.**

a biopsy of a keratinized, rough area of the glans penis which revealed Erythroplasia of Queyrat. The lesion extended over the dorsal surface of the glans penis extending to within a centimeter of the urethral meatus. His past history included a circumcision seven years previously for chronic irritation of the glans and prepuce. One month later, following our initial examination, an excision of the involved area of carcinoma *in situ* with frozen section examination of the margins of resection was done and appeared to be free of disease. The defect was closed with advancement of skin from the shaft of the penis. He did well for the next year, until he noted a small, red, ulcerated area at the superior aspect of the urethral meatus. The area was excised and found to extend approximately three millimeters into the distal urethra. Frozen section of the proximal urethra revealed clear margins for disease. This patient has been followed with periodic urethroscope examinations and to date has been free of disease.

#### Comments

The etiology of Erythroplasia of Queyrat is unknown, but persistent irritation and/or infection has been implicated. If left untreated, Ery-

throplasia of Queyrat will develop into invasive carcinoma. This, however, may take several years. It is interesting that the urethra of the fossa navicularis embryologically develops within the glans penis. The more proximal urethra, developing in the shaft, later joins with the urethra of the fossa navicularis. This developmental process might help explain the involvement of the distal urethra by a condition of the glans penis.

Primary carcinoma of the fossa navicularis has been reported but is relatively rare. This process, however, usually starts in the urethra and extends externally as opposed to the process which we report which apparently began in the area of the glans and extended into the urethra. Interestingly, Meares<sup>1</sup> presents a case report of a patient with carcinoma of the fossa navicularis in which the lesion extended along the urethra into the proximal shaft of the penis but the proximal invasion was not obvious grossly and was only seen microscopically. The apparent normal appearance on gross examination of the proximal urethra in our cases, and that of Meares, would lead one to believe that periodic cystoscopic examination was of little value. While, ideally, amputation of the entire penis could be advocated,

most patients are reluctant to accept this therapy and indeed both of our patients refused amputation.

Various modes of therapy, including irradiation,<sup>2</sup> electrocoagulation, steroid creams, topical fluorouracil,<sup>3,4</sup> excision with primary closure, or skin grafting and amputation<sup>6</sup> have been advocated for the treatment of Erythroplasia of Queyrat. Certainly, if these treatment modalities are to be used, one should keep in mind the potential involvement of the urethra. Care should be taken to determine if involvement has occurred. If so, the urethra itself is treated also by excision or amputation.

#### Summary

Erythroplasia of Queyrat is a carcinoma *in situ* usually involving the mucosa of the glans and sometimes the prepuce. Two cases are presented in which there was extension of this lesion into the distal urethra. While local therapy is usually successful in the treatment of this lesion, involvement of the urethral meatus should make one suspicious of possible extension into the distal urethra. ◀

#### References

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# ISMS Convention Summary 1980

## *Highlights*

### *Summary of Actions*

### *Actions on Resolutions*



# Illinois State Medical Society

## 1980-81 Officers and Board of Trustees

### Officers

PRESIDENT	Herschel Browns, M.D., 4600 N. Ravenswood, Chicago 60640
PRESIDENT-ELECT	Fred Z. White, M.D., 723 N. 2nd Street, Chillicothe 61523
1st VICE-PRES.	Lawrence L. Hirsch, M.D., 2434 Grace, Chicago 60618
2nd VICE-PRES.	George Mitchell, M.D., Cork Medical Center, 410 N. Second Street, Marshall 62441
SEC.-TREAS.	Eugene P. Johnson, M.D., P.O. Box 68, Casey 62420
CHAIRMAN, BOARD OF TRUSTEES	Morris T. Friedell, M.D., 7531 Stony Island, Chicago 60637

### House of Delegates

SPEAKER	Robert P. Johnson, M.D., 108 Maple Grove, Springfield 62707
VICE-SPEAKER	Clifton Reeder, M.D., 734 N. Merrill Ave., Park Ridge 60068

### Trustees

1st District	1981	John Ring, M.D., 511 E. Hawley, Mundelein 60060
2nd District	1983	Allan L. Goslin, M.D., 712 N. Bloomington, Streator 61364
3rd District	1982	Alfred Clementi, M.D., 675 W. Central Rd., Arlington Heights 60005
	1983	Audley F. Connor, Jr., M.D., 7531 Stony Island, Chicago 60649
	1982	Jere Freidheim, M.D., 3050 S. Wallace, Chicago 60616
	1981	Morris T. Friedell, M.D., 7531 Stony Island, Chicago 60649
	1983	Robert C. Hamilton, M.D., 25 E. Washington, Chicago 60602
	1981	Henrietta Herbolsheimer, M.D., 1700 E. 56th Street, Chicago 60637
	1983	Harold J. Lasky, M.D., 55 E. Washington, Chicago 60602
	1983	Richard Rovner, M.D., 645 N. Michigan, Suite 920, Chicago 60611
	1983	Joseph C. Sherrick, M.D., 303 E. Superior, Chicago 60611
	1982	Cyril C. Wiggishoff, M.D., 25 E. Washington, Chicago 60602
4th District	1982	George Burke, M.D., Rock Island Franciscan Hospital, 2701 - 17th Street, Rock Island 61201
5th District	1982	Robert Prentice, M.D., 2248 Warson Road, Springfield 62704
6th District	1981	Robert R. Hartman, M.D., 1515A W. Walnut, Jacksonville 62650
7th District	1982	Alfred J. Kiessel, M.D., 1 Powers Lane Place, Decatur 62522
8th District	1982	James Laidlaw, M.D., 104 W. Clark, Champaign 61820
9th District	1981	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946
10th District	1981	Julian Buser, M.D., 6600 W. Main, Belleville 62223
11th District	1983	Kenneth A. Hurst, M.D., 52 Bunting Lane, Naperville 60540
12th District	1983	Joseph Perez, M.D., 5670 E. State, Rockford 61108
Trustee-at- Large	1981	P. John Seward, M.D., 2500 N. Rockton, Rockford 61103



# Highlights of the 1980 Annual Meeting ISMS House of Delegates

The 140th Annual Meeting of the Illinois State Medical Society convened April 13-15, 1980, at the Chicago Pick Congress Hotel. More than 600 physicians, auxiliaries, medical students, medical residents, and guests attended.

The Credentials Committee recorded attendance of the 1980 House of Delegates as follows:

	First Session 24	Second Session 23	Third Session 26
Officers & Trustees			
Speaker & Vice Speaker	2	2	2
Downstate Delegates	64	72	73
Chicago Medical Soc. Delegates	84	78	87
Intern/Resident	1	1	1
Student	1	1	1
TOTAL	148	177	184

The first session of the House of Delegates was convened by Robert P. Johnson, M.D., Speaker, at 10:30 a.m., Sunday, April 13, 1980.

## A New Tradition

This year, the House initiated a new custom in recognition of former presidents. A past president was invited to lead the House in the opening invocation for each session. On Sunday, the invocation was given by Newton DuPuy, M.D., 1967-68 president.

Willard C. Scrivner, M.D., 1973-74 president, gave Monday's invocation, and on Tuesday the honor was extended to J. Ernest Breed, M.D., 1970-71 president.

ISMS Secretary-Treasurer Audley F. Connor, Jr., M.D., conducted a brief memorial for those ISMS members who had died in the past year.

## Report of the Chairman, ISMS Board of Trustees

Robert R. Hartman, M.D. presented an update



P. John Seward, M.D., (R) presents commemorative plaque and gavel to Robert R. Hartman, M.D., retiring chairman, Board of Trustees.

on Board of Trustees' activity since the 1979 Interim Meeting. All items referred by the House of Delegates had been addressed.

Dr. Hartman particularly noted completion of a membership poll—conducted through the component medical societies downstate—regarding the AMA Ad Hoc Committee Report on Principles of Medical Ethics. Assuming that each downstate physician received the questionnaire, the 1440 responses represented a remarkable 28% return, Dr. Hartman told the House. While the primary purpose of the survey was to guide the Illinois Delegation to the American Medical Association when the proposal is debated in the AMA House, Dr. Hartman identified several specific findings.

The only area showing a difference of opinion by age group was that physicians 30-49 years of age felt heightened activities and legal status of allied personnel required modification of the Principles, while respondents aged 50 and older disagreed. In general, he noted, resident physicians tended to support the existing Principles over proposed revisions more often than any other group of physicians.

Dr. Hartman also highlighted negotiations with the Illinois Department of Public Aid, and the accelerated activity of the Third Party Payment Processes Committee under Fred Z. White, M.D.

Dr. Hartman further commended physician members of IMPAC, whose number increased in the past year from 45% to 56% of all ISMS members.

Among other areas, Dr. Hartman emphasized increased membership as a primary goal for the Society.

## New County Society Chartered

Robert R. Hartman, M.D., chairman, ISMS



(L-R) Merle Swearingen, M.D., delegate, Allan Goslin, M.D., second district trustee, and Robert R. Hartman, M.D., chairman, Board of Trustees, on presentation of Marshall-Putnam Medical Society charter.

Board of Trustees, presented a charter of incorporation for the Marshall-Putnam Medical Society to Allan L. Goslin, M.D., trustee for the second district, at the opening session of the House. Noting that granting a charter for a new component society was "a pleasure we haven't had since 1910," Dr. Hartman congratulated those who had worked to bring the new society together. Dr. Goslin, in turn, presented the charter to Merle Swearingen, M.D., who will serve as ISMS Delegate for the new society.

### Special Presentations

Two plaques commemorating twenty years' service to ISMS were presented at the opening session of the House. "Your Society has been guided by one of the most knowledgeable, innovative of leaders, Mr. Roger White," Dr. Hartman said in presenting that plaque to the ISMS Executive Administrator.

Dr. Hartman also presented a twenty year plaque and notes of appreciation to Betty Karraro, who manages the ISMS Springfield office.

### Reference Committees Convene

Reference Committees met immediately upon House adjournment Sunday afternoon. Open hearings were conducted on 65 resolutions, as well as reports from ISMS councils and committees, affiliate groups and Illinois governmental agencies.

James Duesman, M.D., served as chairman for the Reference Committee on Amendments to Constitution and Bylaws, where proposals rele-

vant to ISMS Judicial Panel and specified duties of ISMS officers were discussed. In addition, proposed amendments to the ISMS Policy Manual were debated.

In Reference Committee A, Richard Blankshain, M.D., guided discussion relating to officers, administration, finance and budgets. Proposed reorganization of ICCME and Policy Manual amendments regarding ISMS adherence to actions by the AMA House, as well as election of AMA delegates, were among issues considered.

Governmental health programs provided primary focus for discussion in Reference Committee B, chaired by Joseph R. O'Donnell, M.D. Professional Standards Review Organizations, state agency coding for reimbursement purposes, as well as IDPA and IDPH activities were discussed.

Education, manpower and clinical medicine were themes for discussion in Reference Committee C, Arthur R. Fischer, M.D., chairman. Carefully considered proposals included those for use of financial penalties to encourage Illinois medical school graduates to practice in the state and amendments to Policy Manual statements and appendix on multiphasic health testing.

Edward Ferrence, M.D., served as chairman for Reference Committee D, responsible for medical services issues and economic matters outside government programs. IDPH regulations governing administration of PKU and T-4 testing services and amendment to Policy Manual statements regarding audits were considered, as well as a Board of Trustees report on study of a proposed Accident and Health Insurance Company.



ISMS Past Presidents (standing, L-R): J. Ernest Breed, M.D., Fredric D. Lake, M.D., Willard C. Scrivner, M.D., Joseph H. Skom, M.D., Edward A. Piszczek, M.D., J.M. Ingalls, M.D., Newton DuPuy, M.D., Jacob E. Reisch, M.D., Frank J. Jirka, M.D., C.J. Jannings, M.D. and Harlan English, M.D. Seated (L-R) are Leo P.A. Sweeney, M.D., E.P. Coleman, M.D., David S. Fox, M.D., George T. Wilkins, Jr., M.D., and Cesar Portes, M.D.



Reference Committee E, chaired by Harold Jensen, M.D., debated proposals relevant to governmental affairs and medical-legal matters. Discussions included activities of physician assistants, and a definition of death as proposed by a model AMA act.

Proposals for a membership recruitment program and discussion of resident physician participation in county medical societies were debated in Reference Committee F, chaired by O. W. Pflasterer, M.D. That Reference Committee was responsible for matters related to public relations, membership and miscellaneous business.

At the conclusion of open hearings, each reference committee met in executive session to evaluate information and comment and make recommendations for consideration by the House of Delegates.

### **Past President's Dinner**

On Saturday evening, April 12, 16 ISMS past presidents gathered for the seventeenth annual Past Presidents' gourmet dinner at the Chicago Mid-America Club. George T. Wilkins, Jr., M.D., 1977-78 president, served as master of ceremonies, and inducted David S. Fox, M.D., as a member of the group.

### **ISMS Fifty Year Club Luncheon**

110 physicians were inducted to the ISMS Fifty Year Club at a Monday afternoon luncheon. The Fifty Year Club now boasts some 910 members, who graduated from medical school at least 50 years ago. Fred Z. White, M.D., presented plaques and pins to new members while serving as master of ceremonies for the luncheon. This year's inductees included Willard C. Scrivner, M.D., 1973-74 ISMS president. Robert Murphy, Esq., legal counsel for the State Medical Society of Wisconsin, addressed the group in a presentation entitled "An Attorney Advisor Looks at the Medical Profession." Over 145 persons attended the festive gathering, sponsored annually to hon-

or members of the Fifty Year Club.

### **Establishing Yourself in Private Practice**

The ISMS Resident Physician Section again sponsored a seminar on the above-captioned topic, conducted by Robert J. Kramer, M.D., on Saturday, April 12. The program is designed to provide guidelines for office management and choice of a potential practice location.

After the educational program, the Resident Physician Section held its annual business meeting. The following 1980-81 officers were elected: Larry Gratkins, M.D., chairman, William E. Golden, M.D., vice chairman, Brad Epstein, M.D., secretary-editor, David Aizuss, M.D., delegate and David Olive, M.D., alternate delegate.

In his written report to the House, Benjamin LeCompte, M.D., outgoing RPS chairman, detailed activities in cooperation with ISMS and AMA-RPS, as well as efforts to streamline internal organization.

### **Human Sexuality**

The ISMS Student Business Section sponsored its educational seminar on Saturday afternoon, April 12. Featured speakers included Anne Seiden, M.D. of Cook County Hospital, on emergency and comprehensive treatment of the rape victim; Harris B. Rubin, Ph.D., SIU School of Medicine and Rehabilitation Institute, on the homosexual patient and Francois Alouf, M.D., Northwestern University Medical School, on the physician's role in sex therapy.

Following the seminar, the SBS annual business meeting featured election of 1980-81 officers: John Diveris, chairman, Michael Nieder, vice-chairman, Jerry Hines, secretary-editor, Ronald Davis, delegate and Lori Anderson, alternate delegate.

SBS chairman David H. Aizuss detailed 1979-80 activity in his written report to the House, including approval of a new SBS constitution which delineates responsibilities and mandates



**Members of the ISMS Fifty Year Club**

semi-annual membership meetings, ongoing educational and membership promotion activities.

### **Alcohol and Substance Abuse: Triage and Treatment**

The ISMS Committee on Alcoholism and Drug Dependence, with the support of a grant from the Division of Alcoholism, IDMHDD, sponsored the above-captioned seminar on Saturday afternoon, April 12. Featured speakers included Edward C. Senay, M.D., committee chairman and professor of psychiatry at the University of Chicago Hospitals and Clinics, who presented a clinical update on abuse of legal and illegal drugs, as well as recent findings relevant to abuse of phencyclidine, "T's and Blues," and marijuana toxicity. Ms. Linda Kyle-Spore, an alcoholism counselor and family therapist at the Northwestern Memorial Hospital Institute of Psychiatry, dramatized family therapy for alcohol abuse with the assistance of volunteer patients who described their therapeutic progress. James W. West, M.D., chairman of the ISMS Panel for the Impaired Physician, assistant professor of psychiatry at Rush-Pres.-St. Luke's Medical Center, and director of alcoholism treatment services at Little Company of Mary Hospital in Evergreen Park, discussed the impaired physician. Dr. West's overview included the nature of common physician impairments and activities by hospitals and physician groups to assist the impaired physician. Stanley E. Gitlow, M.D., a clinical professor of medicine at the Mt. Sinai School of Medicine, New York City and chairman of the Board for Professional Medical Conduct of New York State, as well as a member of the AMA Council on Mental Health, provided a comprehensive alcoholism diagnosis and treatment overview.

### **Physicians in Hospitals: Key to Two Common Questions**

The function of medical staff committees and clues to efficient and effective in-house self government were highlighted at this program, Monday, April 14. The program, which focused on medical staff organization and responsibilities, was directed by Richard E. Thompson, M.D., president of Thompson, Mohr and Associates, Inc., and senior consultant for quality care for the Illinois Hospital Research and Educational Foundation.

### **Doctors' Legal Rights and Responsibilities**

Confidentiality of health records, response to subpoenas, the role of physician as expert witness, hospital staff appointments and disciplinary processes were among topics at a Monday eve-

ning conference sponsored by the ISMS Medical Legal Council. The seminar was co-chaired by Donald Aaronson, M.D., J.D., chairman of the ISMS Medical Legal Council and Fred Grossman, J.D., chairman of the Chicago Bar Association Medical-Legal Committee. Attorneys Herzl E. Levine, Lawrence L. Kotin, Terry Kiwala and Daniel Karlin provided excellent and informative presentations. The program concluded with a lively question-and-answer session.

### **Fourth Annual Workshop For CME Accreditation Surveyors**

This program, sponsored by the Illinois Council on Continuing Medical Education, was held Monday, April 14, and chaired by Harold Paul, M.D. Boyd McCracken, Sr., M.D., provided evolutionary history of the Liaison Committee/CME and Dean Bordeaux, M.D., discussed AMA accreditation procedures. A workshop format and roundtable discussions centered on accreditation site visits and the exchange of ideas and experiences.

Later that day, Robert R. Hartman, M.D., chairman, ISMS Board of Trustees, was assisted by Clifton Reeder, M.D., vice-speaker of the House, in presenting certificates of appreciation to the 26 physicians, osteopaths and Ph.D.'s who had served as accreditation site visit examiners during the past year.

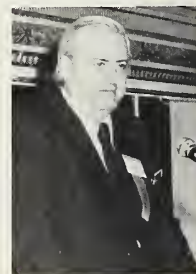
### **ISMS Public Affairs Breakfast**



**Don  
Hinderliter, M.D.**

Congressman Henry Hyde (R) who represents Illinois' sixth district in the U.S. Congress, was keynote speaker for the ISMS Public Affairs Breakfast on Monday morning, April 14. Sponsored by the ISMS Public Affairs Committee and chaired by Don Hinderliter, M.D., the breakfast was well attended. Rep. Hyde discussed national issues, including the windfall

profits tax on oil companies, energy problems and the nuclear power industry. The breakfast was also highlighted by presentation of an AMPAC award to IMPAC for third place in the 1979 total contributions. George T. Wilkins, M.D., presented the award to George Mitchell, M.D., vice-chairman of the IMPAC Council.



**Congressman  
Henry Hyde**



In a related note, the ISMS Auxiliary was also presented the 1979 AMPAC award to IMPAC for first place nationally in total women members.

### Realize Your Auxiliary Potential

Mrs. R. Samuel Hoover, president, ISMS Auxiliary, reported to the House of Delegates on Monday, April 14. Mrs. Hoover repeatedly emphasized the availability of auxiliary members to assist ISMS at every level. "Through the years," she said, "we've held to our primary purpose: to assist you. We are your health education, health program ambassadors. You might call us your community PR agency."



ISMSA President  
Mrs. R. Samuel  
Hoover

Mrs. Hoover reported that the Auxiliary had worked in immunization and physical fitness programs in cooperation with the AMA Auxiliary "Shape Up For Life," campaign. More than 85,000 nutrition education pamphlets and 30,000 "Shape Up" buttons had been distributed throughout Illinois.

"We have over 3000 members in Illinois willing to work," Mrs. Hoover said. "Everyone feels the pressures of what our government is or is not doing these days . . . We have the potential to speak for you—through letter, telephone calls and personal communication. Consider your auxiliary in legislative activity. Realize your auxiliary potential."

Mrs. Hoover included monitoring of public HSA and health planning meetings as examples of grassroots auxiliary support.

The Auxiliary's written report detailed extended activity in community health education, including teen alcohol abuse, CPR, and hospice programs. In addition, the Illinois Auxiliary contributed over \$30,000 to AMA-ERF in the past year—their largest contribution to date.

### Illinois Society, American Association of Medical Assistants

Cissy A. Egly, CMA, AAMA president, was introduced by Allison Burdick, Sr., consultant emeritus to the Illinois Society, AAMA, representing their advisory board.

Ms. Egly told the House the Illinois Society

would complete its first quarter century of existence this year. Her report emphasized ongoing educational activities at the state and county level, as well as their publications, which have been modified to include educational information. Monthly workshops in individual chapters and participation through the travel courses and the Chicago Medical Society Midwest Clinical Conference, Ms. Egly told the House, lend further support to educational efforts.

Ms. Egly stressed loyalty and appreciation to ISMS for continued support and advice.

### AMA-ERF Check Presented

ISMS President P. John Seward, M.D. introduced Morton C. Creditor, M.D., acting executive dean at the UI College of Medicine, representing the Illinois Council of Medical School Deans. This year's contribution for Illinois medical schools from the American Medical Association Education and Research Foundation represented an unrestricted grant of \$151,748.91.



(L-R) Mrs. Hoover, Dr. Creditor and Dr. Seward on presentation of AMA-ERF check

A specific portion of each ISMS member's dues is allocated to AMA-ERF. Members of the Auxiliary also make additional contributions to the fund, which distributes grants to medical schools throughout the United States.

The 1980 AMA-ERF check was presented by ISMS Auxiliary president Mrs. R. Samuel Hoover, to Dr. Creditor, who stressed the role of auxiliary efforts in generating contributions to the fund. Dr. Creditor expressed appreciation for the contribution, noted that the more than \$1,182,000 had been contributed nationally to the AMA-ERF fund by physicians and friends of medicine in the past year.

AMA-ERF funds support student scholarships, scientific meetings, educational publications and a number of other needs in medical education throughout the state.

## Special Guest Address

James Sammons, M.D., executive vice president, American Medical Association, addressed the House of Delegates on Monday afternoon. Dr. Sammons began his presentation with support for earlier statements by Mrs. R. Samuel Hoover on the role of Auxiliary members in promoting health education, recalling his experience on speaking tours with Mrs. Ruth Scrivner as AMA Auxiliary President.

Dr. Sammons' report stressed that ISMS and the AMA are "good neighbors, sharing service as well as enterprise." Defining the purpose of AMA as "the advancement of medicine as a profession and as a means toward the public good," Dr. Sammons described in detail current AMA activities in legislation and litigation, as well as interface with national regulatory agencies.

Inflation can impact on medicine, he emphasized, as budget cuts could detract from medical research funds, and federal demands for increased non-interest bearing reserve on student loans. Mandatory cost controls remain a threat under the present administration, he added, despite clearly documented success of medical self-regulation.

Professional liability would also be a major issue in the future, Dr. Sammons predicted, reporting that 41% more malpractice suits were filed in the first quarter of 1979 than the same period a year earlier. Complimenting the ISMS Claims Flyers as educational vehicles, he called for more stringent risk control programs.

## IMPAC Reports



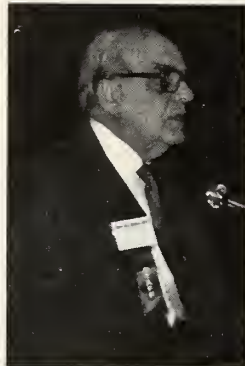
Herbert Sohn,  
M.D., IMPAC  
chairman

Herbert Sohn, M.D., IMPAC chairman, reported that 1979-80 had been a good year for that group. Significant increases had been noted, not only in membership but in the level of activity. "Doctors are becoming more aware of the impact that they can have," he said. "Our members are becoming more and more imaginative—realizing that a

race for Ward Committeeman can be as important as one to the state congress."

Dr. Sohn also updated the IMPAC/AMPAC relationship and thanked all IMPAC members for their active participation.

## Report of the Executive Administrator



Roger N. White, ISMS  
Executive Administrator

Roger N. White, ISMS Executive Administrator, noted that friends of medicine had been told at the AMA Leadership Conference that action in the health care field is moving down to accelerated activity at the state level. "The net result," he said, "is that our Board, Councils and Committees all must

work harder to keep up."

Mr. White's written report reflected this accelerated activity. Extensive legislative and litigative participation, expanded services to specialty societies, financial and membership activities were documented.

Mr. White noted with appreciation the cooperation of auxiliary, student and resident physician groups over the year. Further, he expressed special thanks to the officers and trustees of the Society, for their continued dedication. In a closing note, Mr. White acknowledged the role of Robert R. Hartman, M.D., now retiring as chairman of the ISMS Board of Trustees. "His dedication and zeal," the Executive Administrator declared, "have been an inspiration to the staff."

## Illinois Delegation to the AMA

Herschel Browns, M.D., chairman, Illinois AMA delegation, introduced delegates and alternate delegates, and honorary delegate Frank J. Jirka Jr., M.D., to the House. Dr. Browns thanked them for a year of hard work and loyal effort, and was supported by a standing ovation from members of the House.

The written report of the AMA delegation reflected accelerated activity in questions related to continuing medical education, third party payors and peer review. The Illinois delegates had served on several reference committees during the AMA Interim Session in December, Dr. Browns reported, and proposed six resolutions forwarded by the ISMS House to the AMA House of Delegates.

At the conclusion of this Session, the House elected AMA delegates and alternates for the period January 1, 1981 through December, 1982. Elected delegates were Morris T. Friedell, M.D., David S. Fox, M.D., Henrietta Herbolsheimer,





Members of the ISMS Delegation to the American Medical Association

M.D., Lawrence L. Hirsch, M.D., Joseph R. O'Donnell, M.D., John J. Ring, M.D., Glen Tomlinson, M.D., and George T. Wilkins, Jr., M.D. Alternate delegates elected for that period were Andrew J. Brislen, M.D., Audley F. Connor, Jr., M.D., Allan L. Goslin, M.D., Robert P. Johnson, M.D., Boyd McCracken, Sr., M.D., Clifton L. Reeder, M.D., Richard Rovner, M.D., and P. John Seward, M.D.

### President's Valedictory

ISMS President P. John Seward, M.D., gave his closing comments to the House on Monday afternoon. Dr. Seward's talk traced progress in the past year, and brought forward a call for further efforts.

Tracing evolution of public opposition to national health insurance and mandatory cost control legislation, Dr. Seward said, "During my travels as your president, I was surprised to see both the public and news media exhibit a new sophistication concerning health issues. There is a realization that much of the cost . . . many of the problems . . . and the majority of the paradoxes in our health care system can be traced to govern-

ment's ill-conceived attempt to practice medicine."

"Common sense and expediency dictate that we must be in a position to act on behalf of our members," Dr. Seward told the House. "And that action must be strong, creative, courageous and positive." The outgoing president cited issues surrounding administration of medicaid, cost containment, peer review, physician discipline and health planning. "We must grasp the opportunity," he said, "to lead, to inform, to change, to mold, and, above all, to heal and comfort."

In concluding a moving speech, Dr. Seward recalled a recurring theme of freedom. "The freedom of voluntary action by physicians who are unfettered by artificial restrictions, unencumbered by oppressive bureaucracy, and unimpeded by social planners. The freedom to respond effectively and compassionately to human needs. To treat, to cure, and to comfort."

### President's Night

Tuesday evening, April 15, 285 persons attended the annual gala dinner honoring P. John Seward, M.D., ISMS president. Robert Behmer, M.D., served as master of ceremonies for the program, featuring music by the Mike Pizzuto Trio and the Allan Kaye Orchestra.

The evening was highlighted by Dr. Seward's informal comments and the MC's good-humored



President's Valedictory



Nelson Blome, M.D., (L) receives commemorative plaque from Dr. Seward.

repartee. Entertaining tales from the President's Tour were balanced by Dr. Seward's touching presentation honoring his partner, Nelson Blome, M.D. Dr. Blome, who covered Dr. Seward's practice while the latter fulfilled his duties as ISMS president, was introduced as "my mentor and dear friend."

A special guest, AMA President Hoyt Gardner, M.D., also contributed informal remarks.

### Special Accolades

In the course of this session, two persons received spontaneous recognition from the floor of the House. Speaker Robert P. Johnson, M.D., introduced Frank J. Jirka, Jr., M.D., an honorary member of the AMA delegation and ISMS Past President, to a standing ovation. By special action Morris T. Friedell, M.D., and members of the ISMS Policy Committee received formal acknowledgement for their remarkable work in review and update of the ISMS Policy Manual.

### Herschel Browns, M.D., Inducted As 128th ISMS President

At the final session of the House on Tuesday, April 15, P. John Seward, M.D., administered the oath of office to Herschel Browns, M.D., as the 1980-81 president of the Illinois State Medical Society.

In his inaugural address, Dr. Browns emphasized a need for response to accelerated social change as witnessed by the past decade. "Most of us scarcely remember," he said, "that prior to 1970 there was no Environmental Protection Agency, no National Highway Traffic Safety Administration, no Consumer Product Safety Commission, no Occupational Health and Safety Administration, no Council on Wage and Price Stability, and no Federal Elections Commission . . . regulatory trends have moved our system from independent and individual planning to coordinated, community type approaches."

Recalling the role of economic inflation in health planning, Dr. Browns called upon members to "recognize that there is more to our role in society than providing correct diagnosis and effective treatment. We must recognize that the need for our services and degree of professional freedom will be determined, in increasing part, by its costs, its appropriateness in time and place, and its impact on other social priorities."

Dr. Browns closed his remarks with a call for increased membership activity, particularly addressing physicians employed in non-medical organizations, such as the armed services and



Herschel Browns, M.D., (L) inducted by Dr. Seward as 1980-81 ISMS President.

government. "We need to accept their problems," Dr. Browns reminded the House, "if we expect them to join us."

### Past President's Medallion

Newly installed President Herschel Browns, M.D., presented the Past President's Medallion to P. John Seward, M.D., with notes of appreciation for his contribution to the Society. Robert R. Hartman, M.D., chairman, ISMS Board of Trustees, presented the traditional scrapbook of news clippings from throughout the state to Dr. Seward—noting that this year, three scrapbooks had been required to document his efforts. Those efforts were further commemorated with presentation of a special plaque, honoring Dr. Seward's "devotion to medical science and the art of medical practice."

### Final Business and Elections

At the concluding session of the House, 1980-81 officers were elected unanimously. They are: Fred Z. White, M.D., Chillicothe, president-elect; Lawrence L. Hirsch, M.D., Chicago, 1st vice president; George T. Mitchell, M.D., Marshall, 2nd vice president; Eugene P. Johnson, M.D., Casey, secretary-treasurer; Robert P. Johnson, M.D., Speaker of the House and Clifton Reeder, M.D., vice-speaker.

Elected trustees were: Allan L. Goslin, M.D., second district; Audley Connor, Jr., M.D., Robert C. Hamilton, M.D., Richard N. Rovner, M.D. and Joseph C. Sherrick, M.D., third district; Kenneth A. Hurst, M.D., eleventh district and Joseph Perez, M.D., twelfth district.

Eugene T. Leonard, M.D., Rockford, was unanimously elected to the ISMS Judicial Panel.

At the close of the House, Speaker Robert P. Johnson, M.D. announced that no dues increase would be effected for the coming year. The 1980 interim session House of Delegates will be held October 25-26 at the Continental Regency Hotel in Peoria. ◀



# Summary of Actions

## 1980 Annual Meeting

### House of Delegates

*The ISMS House of Delegates met April 13-15, 1980, and acted on the following items, including nine resolutions carried over from the 1979 Interim Session and 35 resolutions on ISMS policy statements which the Board of Trustees believed were in need of review. Due to the complexity of these actions, only the approved, revised policy statements are reflected in this text. Persons wishing to study the nature of approved changes may refer to the October, 1979, Reference Issue of the Illinois Medical Journal where the former policy statements were published.*

#### OLD BUSINESS

1. Approved an annual \$3.00 per member assessment—beginning in 1981—to support activities of the Resident Physician Section and Student Business Section. (79N-44)

#### REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

1. Amended Ch. VI and VII of the Bylaws to expand duties of the president, president-elect and chairman of the Board of Trustees. The amended Bylaws now read as follows:  
“The president of the Illinois State Medical Society shall lead the Society in all its functions and shall serve as its spokesman. He defends the Constitution and Bylaws, interprets the policies established by the House of Delegates, and works to preserve the unity of the Society. He serves as a member of the Board of Trustees and maintains liaison with the Chairman of the Board and Executive Administrator. He is a member of the Board of Directors of the Educational and Scientific Foundation. He inducts the incoming president and delivers a report annually to the House of Delegates. Upon completion of his term as president, he becomes the immediate past president and serves one year on the Board of Trustees as

trustee-at-large. He may delegate any of his duties.

“The president-elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the president and shall study the responsibilities and duties of the Executive Administrator, chairman of the board and president so that when his term as president commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

“The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.” (80A-7)

2. Amended Ch. XI of the Bylaws to state:  
“The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand, or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.” (80A-11)

3. Referred to the Board of Trustees for further study a proposal that the statement entitled "Autonomy of County Medical Societies," be deleted from the ISMS Policy Manual. (80A-19)
4. Deleted from the ISMS Policy Manual the statements entitled "Conflict of Interest," and "Rebates." (80A-20,27)

## REFERENCE COMMITTEE A

1. Referred to the Board of Trustees for study and report to the 1980 Interim Session a resolution proposing dissolution of the Illinois Council on Continuing Medical Education and assignment of ICCME duties to appropriate ISMS councils and committees. (79N-13)
2. Defeated a resolution calling for creation of a House of Delegates' Overview Committee to observe the Board of Trustees' execution of legislative and policy directives of the House. (79N-30)
3. Deleted ISMS Policy Manual statements entitled "Cooperation with the American Medical Association," and "Lay Employees' Functions," as well as introductory statements in the Policy Manual requiring ISMS adherence to AMA House of Delegates Actions. (80A-6,22)
4. Amended the Policy Manual statement entitled "Election of AMA Delegates," to read:

### ELECTION OF AMA DELEGATES

Delegates to American Medical Association should be elected from those having served as alternate delegates. (80A-21)

5. Amended the Policy Manual statement entitled "Legal Counsel" to read:

### LEGAL COUNSEL

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairmen and county medical societies. Such

inquiries shall be channeled through the Board of Trustees. (80A-23)

6. Amended Policy Manual statement on "Mailing List" to read:

### MAILING LIST

The use of the mailing list of ISMS members must be approved by the Board of Trustees.

7. Amended and consolidated Policy Manual statements entitled "Public Affairs," and "Stationery, Use of," to read:

### PUBLIC STATEMENTS, ENDORSEMENTS

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office. (80A-26)

8. Amended and consolidated Policy Manual statements entitled "House of Delegates, Special Meetings of," Dues and Assessments, Distribution of Information Regarding," and "Dues, Recommendation of the Board to the House" to read:

### DUES APPROVAL PROCEDURE

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates. (80A-28)

9. Filed for information the reports of the President, President-Elect, First Vice President, Second Vice President, Chairman of the Board, Trustee-at-Large, all trustees, Secretary-Treasurer, Executive Administrator, AMA Delegation, Policy Committee, Advisory Committee to the Auxilia-



ry, Auxiliary President, and the American Association of Medical Assistants.

The chairman's report included membership survey results on the AMA ad hoc Committee Report on the Principles of Medical Ethics. The survey was mandated by the ISMS House at the 1979 Interim Session.

## REFERENCE COMMITTEE B

1. Mandated the Society to urge the Illinois Department of Public Aid (IDPA) to establish: (A) A toll-free hotline number so that physicians may call directly to ascertain the status of any claim; and (B) A system of in-house claim numbers to expedite questions about specific claims. (80A-13)

2. Defeated resolutions on IDPA calling upon ISMS to:

- Reject those sections in the *IDPA Handbook for Physicians* which set forth medical record documentation requirements and "insist that only physicians be involved in interpreting medical records in the peer review context." The House believed this proposal was fulfilled recently when ISMS and IDPA reached agreement on a project designed to provide physicians with the right to peer review of disputes resulting from interpretation of medical records during audits. (79N-25)
- Attempt to "block all IDPA desk audits and delivering of recoupment letters" until certain conditions were met. (79N-17)
- Attempt to free Illinois physicians from having to provide a diagnosis code for each patient visit under IDPA's new MMIS system . . . and require IDPA clerical staff to do the coding. The House believed the intent of this subject had been successfully addressed in recent ISMS-IDPA negotiations. (79N-19)

3. Defeated resolutions on PSRO which called upon ISMS to:

- Actively seek an end to PSRO funding by the Federal Government and aggressively pursue repeal of PL 92-603. (79N-23)

- Adopt the position that: "physicians who do not accept assignment for . . . Medicare patients, but who bill . . . directly, have their names and all information concerning them excluded from any PSRO records." (80A-16)

4. Directed the Society to gather data from patients and physicians, including the House of Delegates, regarding "problems they are having with Electronic Data Systems-Federal" and present this and/or related data in testimony at an April 29, 1980, public hearing in Chicago. (80A-17)

5. Urged ISMS and AMA to "work towards implementing the nationwide use of CPT-4 for Medicare Part B reimbursement." (80A-15)

6. Encouraged local health departments and component medical societies to "delineate the roles of the public and private sectors in providing health and medical services to the community by considering: (A) The socioeconomic characteristics of the population to be served; (B) Availability of private medical services; (C) Gaps in medical and health services that should be filled by public health activities; and (D) Coordination and facilitation of direct services should occur in a way as not to duplicate available medical services." (80A-8)

7. Opposed outside fund solicitation by Health Systems Agencies (HSAs); directed the Society to request the Bureau of Health Planning to exclude fund solicitation activities for any HSA; and requested the Illinois Delegation to the AMA to introduce a similar resolution to the AMA House of Delegates. (80A-12)

8. Deleted from the Policy Manual the statement entitled "Comprehensive Health Planning" and adopted the following statement for publication in the Policy Manual:

## HEALTH PLANNING

ISMS urges physician participation in the health planning process at all levels, with strong emphasis on planning at the local community level. ISMS supports health

planning at the local level, and opposes centralized health planning. (80A-53)

9. Filed for information the reports of the Third Party Payment Processes Committee, Committee on Health Planning, Health Data Committee and Task Force on Cost Effectiveness.

## REFERENCE COMMITTEE C

1. Referred to the Board of Trustees for study a proposal to: (A) Encourage medical students whose education is supported by Illinois tax money to practice in Illinois and (B) Seek legislation requiring those who fail to practice in Illinois for at least four years following graduation to reimburse the State of Illinois for the cost of tuition, plus any expenses incurred as a result of legal action taken to enforce this provision. (80A-1)
2. Agreed to amend the Bylaws to require all resolutions presented by the Resident Physician Section and Student Business Section be approved or rejected for consideration by the House on the same basis used for resolutions presented by any other delegates. (80A-3)
3. Recommended that "a moratorium be declared on all new mandatory continuing medical education, re-examination or recertification," and instructed the AMA Delegation to introduce a similar proposal to the AMA House of Delegates. (80A-4)
4. Amended the Policy Manual to combine and clarify statements entitled "Medical Education," and "Medical Schools," to read as follows:

### MEDICAL EDUCATION-SCHOOLS

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences. The Illinois State Medical Society favors admission of students into medical schools on the basis of their ability to be good medical students and physicians. (80A-31)

5. Referred to the Board of Trustees for further study suggested amendments in the policy manual statement on "Multiphasic Screening," a concomitant proposal to delete the appendix on multiphasic health testing from the Policy Manual and suggestions contained in the report of Reference Committee B. (80A-35)
6. Deleted the statement entitled "Communicable Diseases," from the ISMS Policy Manual. (80A-36)
7. Defeated a resolution which called for deletion of the Policy Manual statement entitled "Examinations." (80A-37)
8. Amended specific Policy Manual statements to read as follows:

### MEDICAL DIAGNOSIS AND TREATMENT

While Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis and community standards for medical care. (80A-34)

### EMERGENCY MEDICAL CARE, PROVISION OF

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act. (80A-41)

### ALCOHOLISM

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency towards relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and



their hospitals are encouraged to actively participate in providing services for alcoholics. (80A-44)

### **MEDICAL PSYCHOTHERAPY**

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all its branches. (80A-45)

9. Filed for information were reports from the Council on Education and Manpower, Committee on Accreditation, Publications Committee, Resident Physicians Section, Student Business Section, Student Loan Fund, ICCME and the Educational and Scientific Foundation.

## **REFERENCE COMMITTEE D**

1. Declined to incorporate into the Policy Manual statements from a resolution adopted at the 1977 Interim Meeting entitled "Safeguarding the Human Rights of Illinois Physicians." (79N-3)
2. Referred to the Board of Trustees for further study proposed regulatory amendments in the Illinois Department of Public Health Rules on PKU and T-4 testing. (80A-18)
3. Deleted from the Policy Manual a statement entitled "Prepayment Plans and Organizations," and substituted the following three statements:

### **RELATIONSHIP WITH THIRD PARTY PAYORS**

ISMS should provide guidance, education, communications and negotiations between the membership and third party payors.

### **REIMBURSEMENT FOR OUT-PATIENT SERVICES**

Third Party Payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.

### **REIMBURSEMENT FOR MEDICAL CARE OF PSYCHIATRIC ILLNESS**

Medical care of psychiatric illness should be included in all health insurance policies. (80A-33)

4. Postponed consideration of a proposed amendment to the Policy Manual statement entitled "Audits and Surveys" until the 1980 Interim Meeting. (80A-39)
5. Amended the Policy Manual statement entitled "Veterans Administration," to read as follows:

### **VETERANS ADMINISTRATION**

The Illinois State Medical Society continues to support the concept that a Veterans Administration Hospital should only be concerned with the needs of those patients with service-connected disabilities. (80A-43)

6. Defeated a Board of Trustees resolution calling upon the Society to create a Stock Accident and Health Insurance Company which would issue health insurance policies and supply services in conjunction with Individual Practice Associations desiring to participate. In taking this action, the House considered a feasibility study commissioned by ISMS and prepared by William M. Mercer, Inc. (80A-56)
7. Filed for information were reports from the Councils on Medical Services, Economics and Mental Health and Addiction, Committee on Drugs and Therapeutics, Task Force on Mental Health Code, and the Illinois Departments of Corrections, Rehabilitation and Children and Family Services.

## **REFERENCE COMMITTEE E**

1. Recognized the physician assistant "as a trained health professional;" however it re-

jected a statement calling for ISMS support of increased utilization by hospitals and other employment of the physician assistant in Illinois. (79N-1)

2. Reaffirmed ISMS opposition to compulsory governmentally mandated National Health Insurance; but rejected proposals calling upon the Society to encourage a congressional poll of the citizenry on National Health Insurance and referral of same to the AMA for adoption and implementation. (79N-37)
3. Referred to the Board of Trustees for further study a proposed endorsement of the AMA model state legislation on brain death and a proposal to urge its enactment in the Illinois legislature. (80A-2)
4. Referred to the Board of Trustees for study possible criticism of Illinois Health Facilities Planning Board review criteria and an offer of ISMS expertise in developing a methodology to incorporate projected utilization rates in certificate of need review. (80A-5)
5. Affirmed the right of medical staff members to due process as spelled out in medical staff bylaws before privileges can be terminated. Supported the right of physicians to "continue practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that a condition of their practice is not in the best interest of their patients." Authorized the Board of Trustees to consider filing an amicus brief on behalf of an individual physician or physicians as appropriate in such cases. (80A-9)
6. Defeated a substitute resolution instructing the Illinois AMA Delegation to introduce a resolution calling for Congressional appropriation of funds "for anti-smoking public service announcements on TV and radio or other preventive mechanisms, with an increased federal tax on cigarettes suggested as a source for such funds." (80A-14)
7. Deleted from the Policy Manual a statement entitled "Minors, Medical Treatment of." (80A-48)

8. Amended Policy Manual statements entitled "Medical Testimony, Impartial," and "Abortion," to read as follows:

### **MEDICAL TESTIMONY, IMPARTIAL**

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony. (80A-47)

### **ABORTION**

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement. (80A-50)

9. Referred to the Board of Trustees for study and report back to the 1980 Interim Session House of Delegates a proposed revision in the Policy Manual statement entitled "Experimental Medical Procedures." (80A-52)
10. Expressed great concern and opposition to "broadened application of the doctrine of *res ipsa loquitur* as a method for proving medical negligence under guidelines and edict of the Illinois Supreme Court decision in *Spidle v. Steward*." Requested ISMS legal counsel to review that decision and recommend appropriate action to the Board of Trustees. (80A-54)
11. Filed for information reports from the Governmental Affairs Council, Medical Legal Council, Task Force on New Health Practitioners, Peer Review Appeals Committee, Judicial Panel, ISMIS, Inc., and the Ill. Department of Registration and Education.

### **REFERENCE COMMITTEE F**

1. Mandated that ISMS, in concert with AMA and the component societies, develop a new



member recruitment plan. Instructed the Board of Trustees to present a progress report at the 1981 Annual Meeting House of Delegates. (80A-10)

2. Deleted from the Policy Manual statements entitled "Policy Statements," "Physician-Patient Relationship," and "Cultists, Association with." (80A-25,49,51)
3. Amended and consolidated Policy Manual Statements entitled "Assessments" and "Hospital Staff Assessments" to read:

### ASSESSMENTS

Medical staffs are reminded that hospitals do not have the privilege or right to make compulsory assessments on individual members of the medical staff for building funds or other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments. (80A-30)

4. Amended Policy Manual statements entitled "Placement Service," "Disaster Control," "Alcoholism Education," "Ambulance Services" and "Nutrition" to read:

### PHYSICIAN RECRUITMENT SERVICES

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities. (80A-32)

### DISASTER CONTROL

All medical societies should cooperate with and contribute to disaster plans in their communities. (80A-40)

### ALCOHOLISM EDUCATION

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand

instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged. (80A-46)

### AMBULANCE SERVICES

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards. (80A-38)

### NUTRITION

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority. (80A-42)

5. Appointed an Ad Hoc Committee of the House to study possible amendment of the Policy Manual statement entitled "AMA-ERF," in consideration of a proposal to delete member designation of medical schools targeted to receive individual AMA-ERF contributions. That committee, composed of Drs. Jere Freidheim (Chairman), Howard Burkhead and Mack Hollowell, was instructed to report its findings to the House of Delegates at the 1980 Interim Session. (80A-29)
6. Authorized the ISMS/RPS Governing Council to serve in an advisory role to component societies in planning resident participation at the local level. (80A-55)
7. Filed the reports of the Committee on Insurance and the Council on Public Relations and Membership Services. ◀

# Actions On Resolutions

## April, 1980, Annual Meeting

### House Of Delegates

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
<b>Old Business</b>			
79N-44 (B of T Report "B")	David Whitney (SBS) & William Golden, M.D., (RPS)	Increased Funding for ISMS/SBS & ISMS/RPS	Adopted as Amended
<b>Reference Committee On Constitution &amp; Bylaws</b>			
80A-7	Charles J. Jannings, M.D.	Amendments to Chapter VI and VII of the ByLaws	Adopted as Amended
80A-11	Cyril C. Wiggishoff, M.D.	Amendment to Chapter XI of the Bylaws	Adopted as Amended
Late A 80A-19	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Autonomy of County Medical Societies"	Referred to Board of Trustees
Late B 80A-20	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Conflict of Interest"	Adopted
Late I 80A-27	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Rebates"	Adopted
<b>Reference Committee "A"</b>			
79N-13	William H. Isham, M.D.	Accomplishment of Goal by ICCME	Referred to Board of Trustees to Re- port Back to the House, Oct., 1980
79N-30	Michael Murphy, M.D.	Need for a House of Dele- gates "Watchdog Commit- tee"	Not Adopted



<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
80A-6	Morris T. Friedell, M.D.	Rescinding Policy which Requires ISMS Adherence to AMA House of Delegates Actions	Adopted
Late C 80A-21	Morris T. Friedell, M.D.	Amendment to Policy Manual Statement on "Election of AMA Delegates"	Adopted
Late D 80A-22	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Lay Employees' Functions"	Adopted
Late E 80A-23	Morris T. Friedell, M.D.	Amendment to Policy Manual Statement on "Legal Counsel"	Adopted
Late F 80A-24	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Mailing Lists"	Adopted
Late H 80A-26	Morris T. Friedell, M.D.	Substitute for Policy Statements on "Public Affairs" and "Stationery, Use of"	Adopted
Late J 80A-28	Morris T. Friedell, M.D.	Consolidation and Amendment of Policy Statements on "House of Delegates, Special Meetings of;" "Dues and Assessments, Distribution of Information Regarding;" "Dues, Recommendation of the Board to the House"	Adopted
<b>Reference Committee "B"</b>			
79N-17	Finley Brown, Jr., M.D.	Incompetence	Not Adopted
79N-19	Finley Brown, Jr., M.D.	Coding by State Agency	Not Adopted
79N-23	Ronald M. Severino, M.D.	Funding for Professional Standards Review Organizations	Not Adopted

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
79N-25	Finley Brown, Jr., M.D.	Medical Record Documentation	Not Adopted
80A-8	John J. Ring, M.D.	ISMS Policy on Public Health Department Activities	Adopted as Amended
80A-12	Joseph R. O'Donnell, M.D.	Fund Solicitation by Persons Affiliated with HSAs	Substitute Adopted as Amended
80A-13	Ronald M. Severino, M.D.	Illinois Department of Public Aid "Hotline"	Adopted
80A-15	Ronald M. Severino, M.D.	CPT-4 Coding for Medicare Reimbursement	Adopted
80A-16	Vernon H. Bartley, M.D.	PSRO Invasion of Privacy	Not Adopted
80A-17	Robert J. Becker, M.D.	EDS-F	Adopted as Amended
Late II 80A-53	Morris T. Friedell, M.D.	Replacement of Policy Manual Statement on "Comprehensive Health Planning"	Adopted as Amended
<b>Reference Committee "C"</b>			
80A-1	Charles J. Jannings, M.D.	Tuition Re-imbursement	Substitute as Amended Referred to B of T
80A-3	Morgan M. Meyer, M.D.	Resolutions Presented by the Resident Physicians Section & the Student Business Section	Adopted
80A-4	Joseph R. O'Donnell, M.D.	Moratorium on Mandatory Continuing Medical Education	Substitute Adopted as Amended
Late M 80A-31	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Medical Education"	Adopted



<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
Late P 80A-34	Morris T. Friedell, M.D.	Amendment to Policy Manual Statement on "Medical Diagnosis and Treatment"	Adopted
Late Q 80A-35	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Multiphasic Screening"	Referred to B of T
Late R 80A-36	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Communicable Diseases"	Adopted
Late S 80A-37	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Examinations"	Not Adopted
Late W 80A-41	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Medical Care, Provision of"	Adopted
Late Z 80A-44	Morris T. Friedell, M.D.	Revision of Policy Manual Statement on "Alcoholism"	Adopted
LateAA 80A-45	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Medical Psychotherapy"	Adopted
<b>Reference Committee "D"</b>			
79N-3	Thomas Meirink, M.D.	Safeguarding the Human Rights of the Illinois Physician	Not Adopted
80A-18	J. Robert Thompson, M.D.	PKU and T-4 Testing; IDPH Rules	Referred to B of T
Late O 80A-33	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Pre-payment Plans and Organizations"	Adopted as Editorially Amended
Late U 80A-39	Morris T. Friedell, M.D.	Amendment to the ISMS Policy Manual Statement on "Audits & Surveys"	Postponed until 1980 Interim Meeting of H of D

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
Late Y 80A-43	Morris T. Friedell, M.D.	Amendment to the ISMS Policy Manual Statement on "Veterans Administration"	Adopted as Amended
Late LL 80A-56	Robert R. Hartman, M.D.	Formation of Accident & Health Insurance Com- pany	Not Adopted
<b>Reference Committee "E"</b>			
79N-1	Samuel J. Schimel, M.D.	Recognition of Physicians' Assistants	Adopted as Amended
79N-37	W. H. Brill, M.D.	Congressional Poll on Na- tional Health Insurance Pro- gram	Adopted as Amended
80A-2	Vernon H. Bartley, M.D.	Brain Death	Referred to B of T
80A-5	Walt Stevenson, III, M.D.	Use of Projected Utilization Rates by the Illinois Health Facilities Planning Board	Referred to B of T
80A-9	Lawrence L. Hirsch, M.D.	Hospital Medical Staff Privi- leges	Adopted as Amended
Substitute 80A-14	David Whitney	Anti-Smoking Public Service Announcements	Not Adopted
Late CC 80A-47	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Medical Testimony, Im- partial"	Adopted
Late DD 80A-48	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Mi- nors, Medical Treatment of"	Adopted
Late FF 80A-50	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Abortion"	Adopted
Late HH 80A-52	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Ex- perimental Medical Pro- cedures"	Referred to B of T



<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
Late JJ 80A-54	Mack W. Hollowell, M.D.	The Application of <i>Res Ipsa Loquitur</i> to Medical Malpractices in Illinois	Adopted as Amended
<b>Reference Committee "F"</b>			
80A-10	Lawrence L. Hirsch, M.D.	Membership Recruitment	Adopted as Amended
Late G 80A-25	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Policy Statements"	Adopted
Late K 80A-29	Morris T. Friedell, M.D.	Substitution of Policy Statement on "AMA-ERF"	Adopted as Amended
Late L 80A-30	Morris T. Friedell, M.D.	Consolidation and Amendment of Policy Manual Statements on "Assessments" and "Hospital Staff Assessments"	Adopted
Late N 80A-32	Morris T. Friedell, M.D.	Replacement of Policy Statement on "Placement Service"	Adopted
Late T 80A-38	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Ambulance Services"	Adopted as Amended
Late V 80A-40	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Disaster Control"	Adopted
Late X 80A-42	Morris T. Friedell, M.D.	Amendment to the ISMS Policy Manual Statement on "Nutrition"	Adopted as Editorially Changed
Late BB 80A-46	Morris T. Friedell, M.D.	Revision of Policy Manual Statement on "Alcoholism Education"	Adopted
Late EE 80A-49	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Physician-Patient Relationship"	Adopted
Late GG 80A-51	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Cultists, Association with"	Adopted
Late KK 80A-55	William E. Golden, M.D.	Resident Participation at County Level	Adopted as Amended



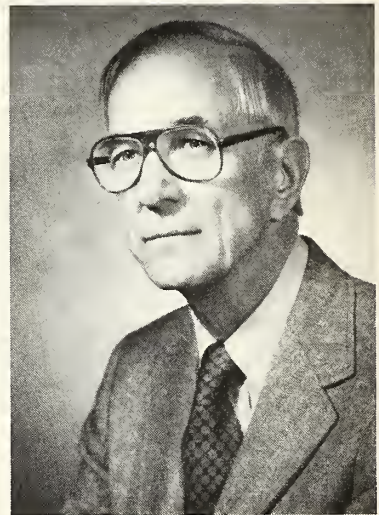
## Convention Scenes

Clockwise, beginning above: House of Delegates' Dias; ISMSA President Mrs. R. Samuel Hoover accepts roses from Dr. Seward before ISMSA House; 1980-81 Auxiliary Board; Post-Convention Board of Trustees Meeting; Alcoholism Education Program; SBS Seminar; Newly-Installed ISMS President Dr. Herschel Browns presents Past President's Medallion to Dr. Seward.





# President's Page



## AN IDEA FOR THE 80's: HOSPICE CARE

In medieval times, a hospice was a way station for travelers on a tough journey. Today, the term "hospice" denotes a health care innovation that allows dying patients to maintain their dignity and sense of self-worth—to be surrounded by people and things they love.

The hospice movement has had a slow start because health insurance provides little coverage for labor-intensive services needed in a home-based setting, the hospice ideal. Many hospice activities are housekeeping-type chores performed for patients and their families by volunteers. It is not desirable for insurance to usurp the volunteer element.

HEW has initiated a two-year demonstration project that will cover all expenses of Medicare and Medicaid patients in 26 hospice programs. Included are hospital-based and free-standing programs and nine home care programs with no in-patient component. The aim is to document net savings achieved by allowing patients—who otherwise would be hospitalized—to live out their lives at home.

Net savings are a key issue because some critics contend that the high cost of a hospice program's personal attention equals—and even may exceed—the cost of high technology therapy associated with hospitalization.

In Illinois, the Health Facilities Planning Board recently amended its classification policy and no longer labels hospice care as "innovative." This turn of events allows hospitals to convert medical/surgical beds for hospice use without obtaining a certificate-of-need . . . and may eliminate the need to construct separate hospice facilities.

ISMS is studying the far-reaching implications of the hospice movement. While a strong case can be made for programs based upon humane ideals, scrutiny is needed. The hospice movement is a classic prototype for a boondoggle.

*Herschel Browns MD*

Herschel Browns, M.D., President

# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

Dear Colleague

As I began my term as IMPAC Chairman, I took some time to review our history so as to get a better perspective on where we might have the greatest impact in the future. Several random thoughts occurred to me which I thought might be of interest to you:

- (1) IMPAC, unlike some other political organizations, was formed by its own members. No other entity, either medical or otherwise, controls it or makes decisions for our members, except our members.
- (2) Some of our most active members have been medical leaders in other areas as well -- some have been officers in the Illinois State Medical Society; others have been local society officers; others have been active in state government.
- (3) Generally our members have always recognized the physician's traditional leadership role in their community.

In considering these factors, it occurred that a number of formerly active ISMS and IMPAC members had not been heard from in recent years -- our retired and emeritus members. I discovered that there are over 1,000 of these physicians scattered around the 50 states.

We recently wrote to these 1,000+ physician leaders to see if we could interest them in again participating in medical political action. Over 200 responded favorably and the responses are still coming in. There appears to be a lesson here and my guess is that it might be that, first of all, our senior physician members are still interested in what we are doing and, secondly, that they still want to help.

My question to you is whether you share their interest and enthusiasm for our programs. If so, contact me at the above address. There is lots to do, and we will be happy to find a spot for you.

Sincerely,



Paul Mahon, M.D.  
Chairman

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.



# ***Abstracts of Board Actions***

*(Continued from page 329)*

## **FREE-STANDING EMERGENCY TREATMENT CENTERS**

During the current General Assembly session, ISMS has opposed HB 1539, a proposal which would provide for separate licensure of free-standing emergency out-patient treatment centers. Controversy exists over the broad question of licensure as well as the specific licensure mechanism, reimbursement, and criteria and standards to ensure quality care. In an effort to develop a position supported by all elements of the health sector, ISMS will: (1) Urge the Illinois Hospital Association, Blue Cross/Blue Shield, Illinois Chapter-American College of Emergency Physicians and other organizations to develop positions on the free-standing centers that address key issues; (2) Convene a meeting of the groups aimed at reaching a consensus on the matter; and (3) Urge HB 1539's sponsor to delay legislative hearings on the proposal until next year.

## **ALCOHOLISM**

ISMS—through its Committee on Alcoholism & Drug Dependence—will assist the IDMHDD Division of Alcoholism in developing a multi-faceted educational program on the synergistic effects of alcohol and prescription drugs. The program will involve: (1) Development of a list of drugs which contraindicate use of alcohol; and (2) Production of warning labels & educational materials for pharmacists. Implementation is mandated by the Illinois State Health Plan which has been approved by Gov. Thompson and now awaits General Assembly consideration. In related action, the Board voted to oppose proposed revisions in HEW regulations that would modify confidentiality safeguards for medical records of alcoholic and drug dependent patients.

## **SPECIAL PROGRAMS**

Acting on requests concerning special programs, the Board voted to:

- Authorize development of a day-long symposium on allied health practitioners. The program—to be held this fall—will be designed to air viewpoints of allied personnel, educators, planners and physicians on the roles and responsibilities of allied health professionals. Details of the program will be presented to the Board in June.
- Authorize the Sports Medicine Committee to seek space on the Chicago Medical Society's 1981 Midwest Clinical Conference program for a half-day sports medicine seminar developed by the Committee.
- Co-sponsor with Blue Cross/Blue Shield a June conference on "High Blood Pressure Control Among Employees." A portion of the program—aimed at chief executive officers of business, labor and industry—will be designed to: (1) Inform them of the need for interventions targeted to employee groups; and (2) Provide suggestions on how to implement worksite high blood pressure programs. The remainder of the conference—aimed at medical directors, benefit administrators, occupational health and safety personnel—will focus on models for employee programs and issues involved in establishing high blood pressure programs.
- Co-sponsor with SIU School of Medicine a May 29 conference in Springfield aimed at developing approaches to improve physician manpower initiatives in Illinois.

## **ADMINISTRATIVE MATTERS**

Several county medical societies are in violation of ISMS Bylaws because one or more of their officers are not members of ISMS and AMA. If the societies refuse to conform to the Bylaws, the Board will act to revoke their charters which are granted by ISMS.

ISMS provides administrative services for six state specialty societies. The arrangement is intended to facilitate coordination of Illinois medicine's action on key issues. A local chapter of a large specialty society recently requested ISMS to provide it with similar services. Formalizing a policy that reflects the objective of such contracts, the Board voted to: (1) Restrict its administrative services to specialty societies that are statewide in scope; and (2) Encourage county chapters of

specialty societies seeking administrative services to contact their respective county medical societies.

The Board approved—subject to review by legal counsel—a new “Procedure for Reconsideration and Appeal of Adverse CME Accreditation Decisions.” Under the new procedure, the ISMS Board of Trustees will rule on appeals of accreditation decisions rendered by the ISMS Committee on CME accreditation.

### HOUSE, BOARD MEETING DATES

Due to problems with hotel arrangements, the 1980 & '81 Interim Sessions of the House of Delegates were rescheduled as follows:

October 25-26, 1980

Continental Regency, Peoria

November 7-8, 1981

Springfield Hilton, Springfield

While the May 16-20 dates for the 1981 ISMS Annual Meeting remain unchanged, the Board will seek an alternative to the Pick Congress Hotel where the session originally was scheduled.

### MOTOR VEHICLE OPERATORS

The Illinois Secretary of State currently requires that a physician attest to an epileptic's ability to operate a motor vehicle before that individual is granted a drivers license. ISMS will urge modification of the requirement so that: (1) A physician is required to attest only to objective information about the disability, diagnosis and prescribed therapy; and (2) The patient is obligated to submit an affidavit concerning the subjective aspects of his ability to operate a motor vehicle.

### IDPA DRUG MANUAL

ISMS will urge IDPA to remove the drugs Wyanoids HC, Anusol HC and Perdiem from the IDPA Drug Manual.

### ELECTIONS/NOMINATIONS/APPOINTMENTS

Third District Trustee *Dr. Morris Friedell*, Chicago, was elected Board Chairman, succeeding *Dr. Robert Hartman*, Jacksonville; Named chairmen of Board committees were: *Drs. Jere Freidheim*, Chicago—Finance Committee; *Lawrence Hirsch*, Chicago, Committee on Constitution & Bylaws; *Fred White*, Chillicothe—Third Party Payment Processes Committee; *Alfred Kiessel*, Decatur—Policy Committee; *Joseph Sherrick*, Northbrook—Publications Committee; and *Julian Buser*, Belleville—Committee on Committees.

Nominated for appointment to state posts were: *Drs. Mack Hollowell*, Charleston-IDPH Board of Public Health Advisors; and *Kermit Mehlinger*, Chicago—IDMHDD Citizens Advisory Council on Alcoholism.

Nominated for appointment to AMA councils and committees were:

- *Dr. Fred White*, Chillicothe—Advisory Committee on Graduate Medical Education
- *Dr. Craig Booher*, Rockford—Liaison Committee on Medical Education
- *Dr. Antonio Scommegna*, Chicago—Liaison Committee on Graduate Medical Education
- *Dr. Morgan Meyer*, Lombard—Committee on Accreditation of CME
- *Dr. Dax Taylor*, Springfield—Advisory Committee on Undergraduate Medical Education
- *Dr. Donald Pochyly*, Chicago—Advisory Committee on CME
- *Dr. Dean Bordeaux*, Peoria—Residency Review Committee on Family Practice
- *Dr. Robert Johnson*, Springfield—Residency Review Committee on Obstetrics-Gynecology.

*Dr. Raphael Campinini*, Chicago, was appointed the ISMS representative to the Illinois Migrant Council.

Acting as corporation members of ICCME, the ISMS Executive Committee elected *J. Linda Gunzburger, Ph.D.*, to the ICCME Board of Directors as a representative of Loyola University Medical School.



# PHYSICIAN VIEWS ON THE PRINCIPLES OF MEDICAL ETHICS

*Reprinted below are items from Supplementary Report No. 1 of Report A of the Board of Trustees to the 1980 House of Delegates, submitted by Robert R. Hartman, M.D., Chairman.*

*The following is a tabulation of physician responses to the ISMS survey on the Principles of Medical Ethics. Total response to the questionnaire from Downstate county medical societies came to 1,440, which represents a 28% return. (5074 questionnaires were mailed to Illinois physicians in Trustee Districts other than District Three.) We want to thank the officers and staffs of the component societies for their cooperation in this project. Some interesting points:*

★ The only area where there was a difference of opinion among physicians of different ages was Question #3. Those 30-39 and 40-49 felt the activities and heightened legal status of allied personnel required modifying the Principles; while respondents 50-60 and 60 and over did not believe this situation necessitates changing the Principles.

★ In comparing the responses of physicians from various practice settings, there were few noteworthy areas of differences.

★ In general, resident physicians tended to support the existing Principles over the proposed revisions in more instances than any other group of physicians.

		YES	NO	NO OPINION	NO RESPONSE
	1. Do you consider the Principles of Medical Ethics obsolete due to changes in statute, legal decisions, and modifications in the health care system?	29%	52%	15%	4%
	2. Do you believe recent actions against organized medicine by the federal government and others necessitate changing the Principles to reduce or eliminate continued exposures to such actions?	45%	36%	14%	5%
	3. Do you believe the activities and heightened legal status of allied health personnel require changes in the Principles?	41%	37%	16%	6%
	4. Which statement, in your view, best explains the overall purpose of the Principles of Medical Ethics?				
EXISTING PRINCIPLE	(A) "These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationships with patients, colleagues, members of allied professions, and the public."			I prefer statement A	55%
				I prefer statement B	43%
PROPOSED REVISION	(B) "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of those whom it serves. As a member of this profession, a physician must recognize responsibilities to society, to patients, to other health professionals and to self. The . . . principles adopted by the AMA are not laws, but standards of conduct which define the essentials of honorable behavior for the physician."			Neither is acceptable	2%

5. Confidentiality of patient information:		
PROPOSED REVISION	(A) "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidence within the constraints of law."	I prefer statement A 46%
EXISTING PRINCIPLE	(B) "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community."	I prefer statement B 51%
		Neither is acceptable 3%
6. The physician's responsibility for self-discipline to protect the public and uphold the law:		
EXISTING PRINCIPLE	(A) "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."	I prefer statement A 44%
PROPOSED REVISION	(B) "A physician shall uphold the honor of the profession by dealing honestly with patients and colleagues and striving to expose those physicians deficient in character, competence, or who engage in fraud or deception" . . . and . . . "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements contrary to the best interests of the patient."	I prefer statement B 45%
		Neither is acceptable 11%
7. The basis upon which a physician practices and relates to other health professionals:		
PROPOSED REVISION	(A) "A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to the public, and utilize the talents of other health professionals when indicated."	I prefer statement A 36%
EXISTING PRINCIPLE	(B) "Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments" . . . and . . . "A physician should seek consultation upon request; in doubtful or difficult cases or whenever it appears that the quality of medical service may be enhanced thereby."	I prefer statement B 62%
		Neither is acceptable 2%
8. The physician's practice choices:		
EXISTING PRINCIPLE	(A) "A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged, he may discontinue his services only after giving adequate notice. He should not solicit patients" . . . and . . . "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."	I prefer statement A 40%
PROPOSED REVISION	(B) "A physician, except in emergencies, shall be free to choose whom to serve, with whom to associate, and the environment in which to provide services consistent with appropriate patient care."	I prefer statement B 56%
		Neither is acceptable 4%



9. The dignity of the patient:					
EXISTING PRINCIPLE	(A) "The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion."	I prefer statement A	36%		
		I prefer statement B	63%		
		Neither is acceptable	1%		
PROPOSED REVISION	(B) "A physician shall be dedicated to providing medically competent service with compassion and respect for human dignity."				
10. The physician's responsibility to the community:					
PROPOSED REVISION	(A) "A physician, as a member of society, shall recognize a responsibility to participate in activities contributing to an improved community."	I prefer statement A	49%		
EXISTING PRINCIPLE	(B) "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."	I prefer statement B	43%		
		Neither is acceptable	8%		
11. Do you believe the following statements should be included in the Principles of Medical Ethics?		YES	NO	NO	NO
EXISTING PRINCIPLE	(A) "In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.	68%	24%	5%	3%
EXISTING PRINCIPLE	(B) "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle."	60%	24%	8%	8%
12. What is your age group?					
		30 to 39 28%			
		40 to 49 25%			
		50 to 59 25%			
		60 and over 22%			
13. What type of practice are you in?					
		Private practice—office based 72%			
		Private practice—hospital based 16%			
		Full time non-teaching			
		hospital staff 1%			
		Medical teaching, administration or research 4%			
		Resident 1%			
		Other (specify) 6%			

### Total Responses From Downstate County Medical Societies

Adams .....	51	Clay .....	5
Alexander .....	3	Clinton .....	
Bond .....	5	Coles-Cumberland .....	17
Boone .....	7	Crawford .....	1
Bureau .....	17	DeKalb .....	20
Carroll .....	5	DeWitt .....	1
Cass-Brown .....		Douglas .....	5
Champaign .....	99	DuPage .....	106
Christian .....	5	Edgar .....	6
Clark .....	9	Edwards .....	

Effingham		McLean	10
Fayette		Menard	
Ford	7	Mercer	1
Franklin	10	Monroe	5
Fulton	14	Montgomery	12
Gallatin		Morgan-Scott	16
Greene	2	Moultrie	
Hancock	7	Ogle	11
Henderson	2	Peoria	24
Henry-Stark	17	Perry	5
Iroquois	2	Piatt	
Jackson	13	Pike	4
Jasper		Pulaski	
Jefferson-Hamilton	5	Randolph	11
Jersey-Calhoun	3	Richland	11
JoDaviess		Rock Island	76
Johnson		St. Clair	2
Kane	76	Saline-Pope-Hardin	16
Kankakee	27	Sangamon	110
Kendall	5	Schuyler	1
Knox	9	Shelby	3
Lake	125	Stephenson	24
LaSalle	1	Tazewell	17
Lawrence		Union	2
Lee		Vermilion	31
Livingston	13	Wabash	
Logan	10	Warren	5
Macon	30	Washington	2
Macoupin		Wayne	4
Madison	61	White	
Marion		Whiteside	20
Mason		Will-Grundy	61
Massac		Williamson	7
McDonough	14	Winnebago	126
McHenry	1	Woodford	6

### Physician Responses By Specialty

This chart compares responses of physicians in various specialties to those of all respondents. The numbers across the top of the chart correspond to questions on the attached survey form. Coding: N = "No"; Y = "Yes"; S = Responses were equally split between the two choices.

	Question #1	2	3	4	5	6	7	8	9	10	11A	11B	TOTAL RESPONSES
All Respondents	N	Y	Y	A	B	B	B	B	B	A	Y	Y	1440
<u>Specialties</u>													
Family Practice	N	Y	Y	A	B	B	B	B	B	A	Y	Y	378
Internal Med., Card., Allergy, Pul. Med., Gastro.	N	Y	Y	A	A	A	B	B	B	A	Y	Y	216
OB-Gyne.	N	Y	Y	B	B	B	B	B	B	B	Y	Y	85
General Surgery	N	Y	Y	A	B	B	B	S	B	B	Y	Y	150
Radiology	N	N	Y	A	B	B	B	B	B	A	Y	Y	76
Orthopedics	N	S	N	A	S	B	B	B	B	A	Y	Y	49
Pediatrics	S	Y	Y	A	A	A	B	A	B	A	Y	Y	65
Psychiatry	N	Y	N	A	B	B	B	B	B	A	Y	Y	60
Pathology	N	Y	Y	A	A	B	B	S	A	A	Y	Y	46
Anesthesiology	N	Y	Y	A	B	B	B	B	B	A	Y	Y	66
Ophthalmology	N	Y	N	A	A	B	B	B	B	A	Y	Y	59
Urology	N	Y	S	B	B	A	B	B	B	B	Y	Y	37
Emergency Medicine	N	N	N	A	B	S	S	B	B	A	Y	Y	14
Neurology, Neurosurgery	N	Y	N	A	S	A	B	B	B	A	Y	Y	29
Public Health, Preventive Medicine	S	Y	S	A	A	A	B	B	B	A	Y	Y	9
Thoracic, Plastic Surgery	N	Y	Y	B	A	A	S	B	B	A	Y	Y	21
Dermatology	S	Y	S	A	A	A	B	B	B	A	Y	Y	20
Otolaryngology, ENT	N	Y	N	A	B	A	B	B	S	A	Y	N	19
Rehabilitation, Occupational Med.	N	N	N	A	A	A	B	B	B	A	Y	Y	20
None listed													21



# Illinois Society, American Association of Medical Assistants

## AAMA, ILLINOIS SOCIETY, 24th Annual Convention

*Over 200 Medical Assistants convened at the Arlington Park Hilton Hotel recently for a very successful convention. The educational sessions were well attended and Continuing Education Units (CEUs) were awarded to the participants.*



**Advisors:** (Left to right) Thomas Harwood, M.D., Robert Hartman, M.D., John Wright, M.D., and Allison Burdick, Sr., M.D.



(Left to right) Cissy A. Egly, CMA, outgoing president, Luella V. Mitchell, chairman, public relations, Elaine Kaiser, CMA-A, incoming president, Helen Smith, convention chairman and Maxine Coody, AAMA national representative.



**Luella Mitchell, speaker of the house of delegates.**



*1980-1981 Officers*

**Front Row (left to right):** Mary Palmer, 1st vice president, Mary Lu Ostrowski, CMA., president elect, Dianne Ruedger, corresponding secretary, Elaine Kaiser, CMA-A, president and Pauline Klarich, vice speaker of the house

**Second Row (left to right):** Sheri Everhart, historian, Thomas Harwood, M.D., Advisor, Cissy A. Egly, CMA., immediate past president, Patricia Mooney, RN, treasurer, Robert Hartman, M.D., advisor, Jean Fouts, LPN, 2nd vice president, John Wright, M.D., advisor, Ruby Jackson, CMA, parliamentary advisor, Luella Mitchell, speaker of the house and Edith Whelan, recording secretary.

**Not in picture -** Jackie Chesley, CMA-C membership secretary.



**Ruby Jackson, CMA, accepting awards for Chicago Chapter.**

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3310, Chicago, 60603.*

**ATKINSON:** A modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond-Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles to Peoria (UI). All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235 (309-936-7566). (7)

**BLOOMINGTON:** Physician to work in anesthesia mornings, general practice afternoons. Space available in clinic with podiatric group of 4 doctors. Attached ambulatory surgical facility. Central Illinois community, area population over 100,000. 135 miles from Chicago, near Universities and Colleges. For further information contact: Dr. H. R. Hadden, 2708 Mc Graw Dr., Bloomington 61701 (309-633-2306). (8)

**CHICAGO AREA SUBURBS:** Western Cook, DuPage Counties, including Oak Brook, Downers Grove, Wheaton, Lombard, LaGrange, Palos Hills. Opening in new and established multi-specialty medical groups. Complete office facilities with nearby hospital affiliations. Various practice and financial arrangement available. General Practice, Internal Medicine, Family Practice, Obstetrics & Gynecology, Otolaryngology, and Orthopedic Surgery. CONTACT: Jim Gott, Administrator, Suite 205, 6800 S. Main Street, Downers Grove, 60515, 312-852-9400. (12)

**EFFINGHAM:** Anesthesiologist needed to assume the position of Director of Anesthesia Services. Excellent hospital facilities with a spacious new surgery department and a service area of 75,000 population. Opportunity available combining the convenience of urban living with a progressive rural community designated a growth area. Effingham is located in south central Illinois at the intersection of two major interstate highways, I-70 & I-57, and offers excellent school systems and recreational activities. Respond with CV to: James M. Brophy, St. Anthony's Memorial Hospital, 503 N. Maple Street, Effingham, 62401 (217) 347-1324. (9)

**DAVENPORT, IA:** Ten man group with two OB-GYN's seeks another OB-GYN partner. Attractive offer now with promising future. Send C.V. We will call. Gordon Rock, M.D., The Davenport Clinic, 1820 West Third Street, Davenport, Iowa 52802. (7)

**DEKALB:** Northern Illinois University, a state university of approximately 22,000 enrollment, needs a sports medicine/emergency room physician to serve as university team and trauma room physician. Qualifications: Illinois license to practice medicine and surgery and pertinent experience in sports medicine and trauma care. Salary competitive; good fringe benefits. Ten or twelve months

per year. To start July 1 or August 1, 1980. Contact: Loren W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, 60115. Northern Illinois University is an Equal Opportunity/Affirmative Action employer. (7)

**DANVILLE:** Multispecialty Group in new building seeking E.N.T., F.P./G.P., Cardiologist, Neurologist, and Ophthalmologist. Salary with early shareholding and income based on productivity. Excellent corporate benefits. Central Illinois/Indiana border location. Contact: A. Reese Matteson, M.D., Danville Poly-clinic, Ltd., 101-103 W. North, Danville 61832. (217-446-6410) (9)

**EL PASO:** Family practitioner for rewarding primary care and family physician. Fully equipped office in excellent location. Primarily farming community in North Central Illinois. Fifteen miles from hospitals in Normal-Bloomington with cultural advantages of two universities—Illinois Wesleyan, and Illinois State University. Ten miles from Eureka Hospital and 35 miles to Peoria with U of Ill Medical School and Bradley University. Financing available. A warm, personal community that would welcome a needed physician. CONTACT: Kearney Clinic, 3 Grant Street, El Paso 61738 (309-527-5752). (7)

**FAIRBURY:** Primary Care and Family Practice Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739 (815-692-2346). (12)

**FREEPORT:** Urologist, Ob-Gyn, and General Surgeon, Board Certified or Eligible, to join multi-specialty group in community of 35,000 in Northern Illinois. Salary negotiable first year, then partnership. Excellent retirement and fringe benefits. Send curriculum vita and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, Illinois 61032. (815-235-6131) (7)

**FREEPORT:** Orthopedic Surgeon—Pediatrician—Otolaryngologist—Needed to join 20 physician, multi-specialty clinic. New facilities, fully equipped, adjacent to hospital. Attractive financial arrangement with many fringe benefits. No investment. Contact J. S. Schoenberger, Business Manager, Freeport Clinic, S. C., 1036 West Stephenson Street, Freeport, 61032, AC 815/235-5111. (12)

**FRANKFORT:** Pediatrician wanted for 10 man multi-specialty group, thirty miles southwest of Chicago. Profit sharing, new building and excellent practice op-



portunity. Contact: Howard Osmus, Administrator, Hedges Clinic, Frankfort 60423 (815-469-2123). (8)

**HINSDALE:** Western suburbs of Chicago. Wholistic Health Center of Hinsdale. Facilities already established in the Union Church. Prefer certification or experience in Family Practice. Must be committed to working with team. Salary and contract negotiable. Contact Dr. John Payne, 137 S. Garfield, Hinsdale, Il., 60521. (7)

**JOLIET:** General Practitioner—opening available in medical clinic consisting of four GP's and two Surgeons. Salary for one to two years and then full partnership. Located in city of 100,000, close proximity to Chicago. Excellent schools, good cultural environment. Salary is negotiable. Alternate night calls with GP's in group. Write: Family Medical Group, S.C., 330 Madison St., Joliet 60435 or call: 815-735-3440. (11)

**MT. VERNON:** Board Certified or Eligible OB-GYN to join 36 year old established same in rapidly growing town of 20,000 with good schools, nice people, lots of recreational opportunities and easy access to St. Louis. Modern 200 bed JCAH hospital; new office in the works. Good initial salary and benefits and early partnership. CONTACT: Tom Weinberg, M.D., PO BOX 1604, Mt. Vernon 62864 (618-244-2235). (8)

**OBLONG:** Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum

salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

**PALMYRA:** Population 800, three more villages in our school District. No doctor at present. New doctor's office equipped free of charge, utilities furnished. Hospital less than an hour drive, ambulance service, recreational facilities, and nearby airport. CONTACT: Oral Cooper, Village of Palmyra, Palmyra, 62674 (217-436-2521). (8)

**PEKIN:** Family practice physician needed. City Population 40,000, county population 130,000. We are looking for a high-caliber professional to join the staff of our modern 206 bed hospital. Our hospital features a full range of modern, well maintained support services and excellent nursing care. Our community has an outstanding school system, the second largest park system in the State of Illinois (over 2,000 acres), two country clubs, four golf courses and beautiful residential areas. Our recruiting package includes an income guarantee competitive with anyone in the country, office expense allowance, moving expenses and assistance in securing home and business loans through local banks. Contact: Robert Tucker, M.D. or Norman F. Webb, Administrator, Pekin Memorial Hospital, Court & 14th Streets, Pekin 61554 (309) 347-1151. (11)

**PINCKNEYVILLE:** General Surgeon to replace present Board Certified Surgeon, leaving for fellowship. Board Eligible or Board Certified to join three family practitioners in four man group. Modern Hospital and Medical Building. For details call 618-357-2131. Pinckneyville Medical Group, 206 N. Main, Pinckneyville 62274.

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CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives  
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SPRINGFIELD OFFICE: W. J. Nattermann, Representative

Suite 580, One North Old Capitol Plaza, Springfield 62705 (217) 544-2251

# Viewbox

(Continued from page 331)

## DIAGNOSIS: FELTY'S SYNDROME

All of the choices listed can cause calcaneal erosions near the insertions of the Achilles tendon (Figure 1) or plantar aponeurosis. The highest incidence of symptomatic heel lesions occur in Reiter's syndrome and psoriatic arthritis. Occasionally a patient with one of these arthritides presents with heel symptoms. Lateral heel radiographs suggest the diagnosis when erosions or poorly margined "fluffy" calcaneal bone spurs are present.

Shoulder erosions (Figure 2) are common in rheumatoid arthritis, ankylosing spondylitis, and lipoid dermatoarthritis, which is a rare systemic disorder affecting skin and synovium and causing an erosive polyarthritis. Psoriatic arthritis and Reiter's syndrome seldom affect the shoulders.

Splenomegaly in a patient with rheumatoid arthritis can be due to Felty's syndrome, amyloidosis, Sjogrens syndrome, iron deficiency anemia, lymphoma (increased incidence in RA), or an unrelated problem.<sup>1</sup>

Felty's syndrome occurs in about 1% of patients with RA. (The patients usually have long standing, severe RA). The most common findings are splenomegaly, leukopenia, neutropenia, lymphocytopenia and anemia. Less common are hepatomegaly, lymphadenopathy and asymptomatic thrombocytopenia. Recurrent severe infections are frequent and often lead to the discovery of Felty's syndrome. Chronic anterior tibial leg ulcers are found in about 20%.<sup>2</sup> The etiology of neutropenia is unknown and the infections correlate poorly with the severity of neutropenia. One hypothesis is that granulocyte-specific antibodies coat granulocytes leading to sequestration and destruction in the spleen.

Splenectomy has been advocated as treatment, especially in patients with chronic leg ulcers, sepsis, and very large spleens. There are mixed reports concerning the results of splenectomy. Patients have had cessation of infections, no change in infections, and even infection and death following splenectomy.<sup>1-3</sup>

### References

1. Hollingsworth, J.W.: MANAGEMENT OF RHEUMATOID ARTHRITIS AND ITS COMPLICATIONS, Year Book Medical Publishers, Chicago, 1978.
2. Sienknecht, W., Urowitz, M.B., Pruzanski, W., et al: "Felty's Syndrome," *Ann. Rheum. Dis.* 36:500, 1977.
3. Laszlo, J., Jones, R., Silberman, H.R., et al: "Splenectomy for Felty's Syndrome," *Arch. Int. Med.* 138:597, 1978.

## BRIEF SUMMARY

**Indications**—Symptomatic relief of anxiety and tension associated with anxiety disorders, other psychoneurotic disorders, transient situational disturbances, and functional or organic disorders. Symptomatic relief of acute alcohol withdrawal.

Effectiveness in long-term use (over 4 months) not assessed by systematic clinical studies. Physician should periodically reassess usefulness for each patient.

**Contraindications**—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

**Warnings**—Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 18. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**Precautions**—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**Adverse reactions**—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

**Dosage**—ANXIETY—Usual daily dose 30 mg or less (start the elderly or debilitated at 7.5-15 mg). Adjust gradually within 15-60 mg daily range. Capsules and scored tablets: divided doses, or once daily h.s. (start patient at 15 mg). Single Dose Tablets, 22.5 mg (for patients stabilized on 7.5 mg t.i.d.) or 11.25 mg once daily at any hour. ALCOHOL WITHDRAWAL—In divided doses. 1st day 30 mg initially, then 30-60 mg. 2nd day 45-90 mg; 3rd day 22.5-45 mg, 4th day 15-30 mg. Then taper to 15-7.5 mg daily, and discontinue as soon as stable.

**Interactions**—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants.

**Overdosage**—Take general measures as for any CNS depressant.

**Supplied**—Tranxene 3.75, 7.5, and 15 mg capsules and scored tablets. Tranxene-SD Half Strength 11.25 and Tranxene-SD 22.5 mg single dose tablets.

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North Chicago, IL 60064



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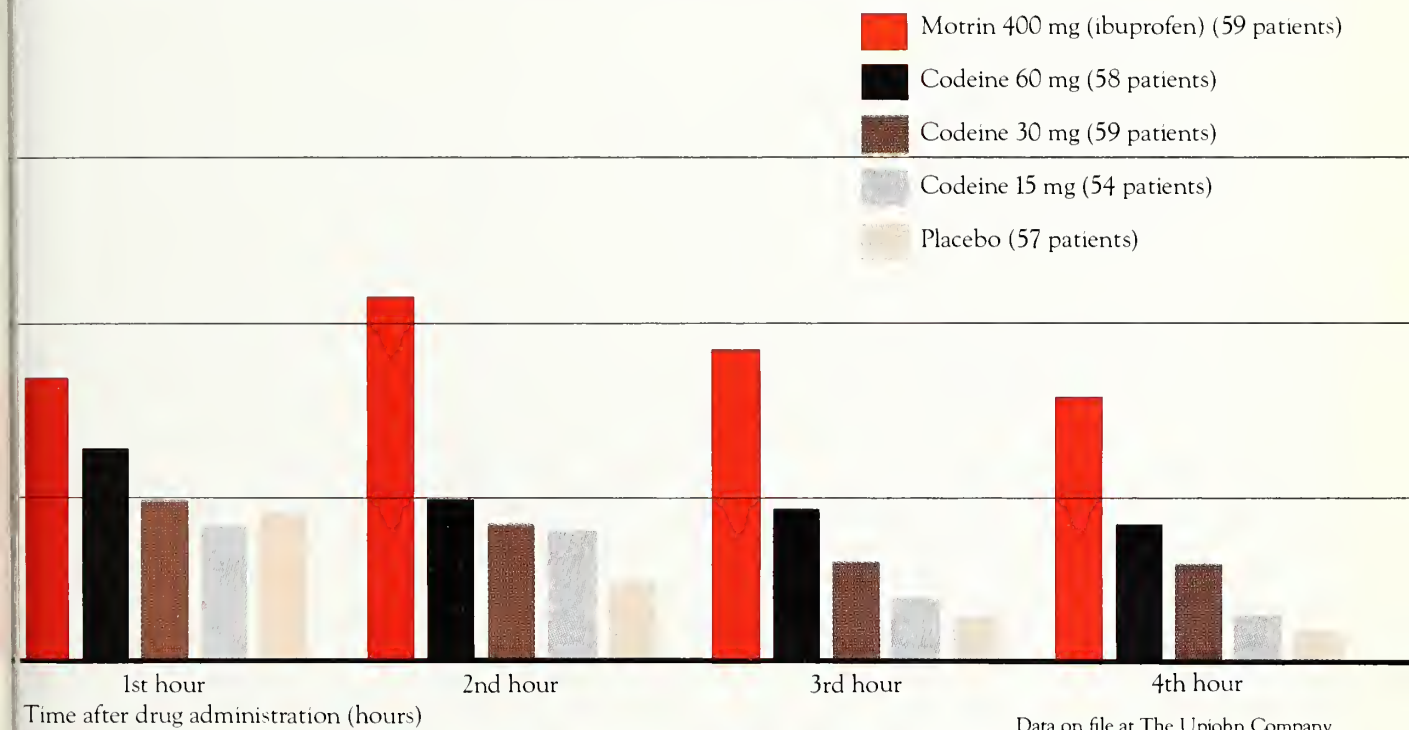


# compare the analgesic effect

Motrin (ibuprofen) 400 mg tablets provided greater relief of pain than codeine in a double-blind, randomized clinical study of 287 patients. Motrin was significantly more effective ( $p < 0.01$ ) than codeine 60 mg at the 1-, 3- and 4-hour intervals...significantly more effective ( $p < 0.01$ ) than codeine 30 mg, codeine 15 mg, and placebo at all intervals.

## Degree of pain relief—mean scores

= Excellent relief   3 = Good relief   2 = Fair relief   1 = Poor relief   0 = No relief



One tablet q4-6h prn pain

well-tolerated, nonnarcotic prescription for mild to moderate pain

**Motrin**<sup>®</sup> 400mg TABLETS  
 ibuprofen, Upjohn

Not a narcotic • Not addictive • Not habit forming • Acts peripherally  
 Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated  
 The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

**Upjohn**

**Motrin<sup>®</sup>** (ibuprofen)

## now proved an effective analgesic for mild to moderate pain

**Motrin<sup>®</sup> Tablets** (ibuprofen, Upjohn)

**Indications and Usage:** Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

### Adverse Reactions

#### Incidence greater than 1%

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,\* epigastric pain,\* heartburn,\* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,\* headache, nervousness. **Dermatologic:** Rash\* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

\*Incidence 3% to 9%.

#### Incidence less than 1 in 100

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

**Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

#### Causal relationship unknown

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

**Caution:** Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

## EKG

(Continued from page 335)

**Answers: 1. C, D 2. D**

The twelve lead ECG shows non-specific or non-diagnostic ST-T wave changes suggesting metabolic or electrolyte imbalance, most often hypokalemia. There is a negative U wave following the flattened T wave that is seen best in leads V<sub>2</sub>, V<sub>3</sub>, V<sub>4</sub> and V<sub>5</sub>. There is no evidence for an acute myocardial infarction or left ventricular hypertrophy. However, inverted U waves are described in ischemic heart disease and left ventricular hypertrophy. Furthermore, we knew the patient was in reasonable electrolyte and metabolic balance. With these data and the presence of findings suggesting a metabolic encephalopathy, hypophosphatemia was suspected. This was confirmed with a serum phosphorus level of 0.5mg/dl and a serum calcium of 8.5mg/dl. A phosphate infusion was started and the patient subsequently regained consciousness. At this time the twelve lead ECG was entirely normal. All of the answers given in question #2 are true. More than twenty-five years have passed since hypophosphatemia was a topic of concern in the literature. It has become important again because it can occur under a variety of circumstances and cause serious morbidity. Although our patient had no evidence of congestive heart failure, three patients have recently been reported with a reversible congestive cardiomyopathy and severe hypophosphatemia in this range. These were reversed by correction of the hypophosphatemia. (Darsee *et al: Annals Internal Medicine* 89:867, 1978). For an extensive review of severe hypophosphatemia, see Knochel: *Archives Internal Medicine* 137:203, 1977.

MED B-4-S

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# Doctor's News

**PHYSICIANS IN THE NEWS**—The 1980-81 officers inducted at the recent annual meeting of the ISMS House of Delegates are: **Herschel Browns, M.D.**, Evanston, president; **Morris T. Friedell, M.D.**, Chicago, chairman, Board of Trustees; **Robert P. Johnson, M.D.**, Springfield, speaker of the house; **Fred Z. White, M.D.**, Chillicothe, president-elect, **Lawrence L. Hirsch, M.D.**, Chicago, 1st vice-president; **George Mitchell, M.D.**, Marshall, 2nd vice-president, **Eugene Johnson, M.D.**, Casey, secretary-treasurer and **Clifton Reeder, M.D.**, Park Ridge, vice-speaker

**Ruy V. Lourenco, M.D.**, Chicago, has been elected to the Association of American Physicians, an association for doctors who have made significant contributions to medicine in the U.S. Dr. Lourenco, professor and chairman of the department of medicine at the UI College of Medicine and UI Hospital, has written over 100 papers dealing with clinical, physiological and biochemical aspects of respiratory and pulmonary disease.

Newly installed officers of the Illinois Academy of Family Physicians include **Eugene S. Welter, M.D.**, Aurora, president; **Carl Neuhoff, M.D.**, Peoria, president-elect; **John E. Meyenberg, M.D.**, Chicago, vice-president; **Lawrence Plummer, M.D.**, Jerseyville, chairman, Board of Directors; **Mack Hollowell, M.D.**, Charleston, speaker of the Congress of Delegates; **E. Chester Bone, M.D.**, Jacksonville, national delegate to the AAFP and **Paul M. Schmidt, M.D.**, Galva, national alternate delegate to the AAFP. In addition, the Academy elected **Delbert O. Williams, Jr., M.D.**, Stockton, **Hobart Don Blair, II, M.D.**, Tremont and **Mark Kanaris, M.D.**, Oak Lawn, as members of the IAFP Board of Directors.

**Casper M. Epstein, M.D., D.D.S.**, Chicago, has been elected to the board of directors for the International College of Surgeons Hall of Fame and Museum of Science. A past president of the Chicago Medical Society, Dr. Epstein is clinical professor of surgery at the University of Health Sciences/ Chicago Medical School.

St. Francis Hospital of Evanston recently elected the following physicians as medical staff officers: **Franklin T. O'Connell, Jr., M.D.**, Chicago, president; **Frederick Gau, M.D.**, president-elect and **Philip H. Sheridan, M.D.**, Skokie, secretary-treasurer. Elected members-at-large for their executive committee: **Myles Cunningham, M.D.** Chicago, **Denis Drennan, M.D.**, Evanston and **George McDermott, M.D.**, Skokie.

Newly named officers for the Chicago Society of Plastic Surgery are: **Martin C. Robson, M.D.**, president, **Richard L. Sperling, M.D.**, Skokie, vice president, **Norman E. Hugo, M.D.**, secretary and **Randall E. McNally, M.D.**, Chicago, treasurer.

Three ISMS members will be among nominees for election to AMA Councils at the AMA House of Delegates Annual Meeting in June. They are **Jack L. Gibbs, M.D.**, Canton, for the Council on Medical Education and **L. Ann Nunnally, M.D.**, Chicago for the resident position on that Council. **John J. Ring, M.D.**, Mundelein, is nominated for re-election to the Council on Medical Service.

**Daniel X. Freedman, M.D.**, Chicago, has been named president-elect of the American Psychiatric Association. **Robert A. DeVito, M.D.**, Downers Grove, will conclude his service as director of the Illinois Department of Mental Health and Developmental Disabilities, effective June 30. Dr. DeVito has announced that he plans to accept a position as chairman of the Department of Psychiatry, Loyola University Stritch School of Medicine.

**LICENSE RENEWAL UPDATE**—License renewal forms were mailed out by the Department of Registration and Education, the second week of April, to all physicians holding Illinois licenses. They were sent to the last address of record of each licensee. If you did not receive a license renewal form, immediately contact the Medical Licensure Section, Department of Registration and Education, 320 W. Washington St., Springfield IL 62786.

The Department has announced that a 5% random sample of Illinois physicians will receive license *extensions* through September 30, rather than license renewals. This random sample will be required to verify their CME credit earned, for the license renewal period. Verification will be requested by August 21, 1980.

**CONTINUING EDUCATION UPDATE**—The AMA will sponsor a three-day program, September 19-21, at the Chicago Marriott Hotel. Part of a continuing series of regional physician education meetings, subject matter is multi-disciplinary and planned for value to most practicing physicians. Further information may be obtained by writing the AMA Council on Continuing Physician Education, Ms. Gale Jewett, 535 N. Dearborn St., Chicago, IL 60610; (312) 751-6570.

**DIABETES HEALTH CARE SYMPOSIUM ANNOUNCED**—The American Diabetes Association, Northern Illinois Affiliate, will sponsor a symposium Monday and Tuesday, September 8-9, at the Chicago Radisson Hotel. Lectures and workshops for physicians and allied health professionals are planned. Further information may be obtained by writing the Association at 620 N. Michigan Ave., Chicago IL 60611; (312) 943-8668.

**QUALITY ASSURANCE SEMINARS ANNOUNCED**—The American Hospital Association will sponsor two concomitant seminars this summer, August 13-15, at the O'Hare Hilton, Chicago. "Quality, Trending and Management-80: A Hospital-Wide Quality Assurance Program," is designed to provide administrators and staff with information and tools to evaluate quality assurance activities and meet new requirements. "QTM-80-The Physician's Role," is intended to inform medical staff of their roles and responsibilities in quality assurance and risk management programs. Each seminar carries Category 1 CME credit for physicians. Further information may be obtained by contacting Lindy Ellis, educational coordinator, American Hospital Association, 840 N. Lake Shore Dr., Chicago IL 60611; (312) 280-6446.

**ICCME NOW CHARGES FOR PLANNING HANDBOOKS**—The Illinois Council on Continuing Medical Education has adopted a new pricing formula for their CME Planning Handbooks and reprints. The price will be computed to cover accelerated printing and production costs. A 50% discount will be available to ISMS members.

A new Catalog/Order Form reflecting the new pricing policy is now available. It lists ICCME's latest publication, its first on evaluation: *Physicians Improve Performance Through Continuing Education* (\$7.00 postpaid; less 50% for ISMS members). For your copy of the Catalog/Order Form, call the ICCME office (312/236-6110) or write "Catalog/Order Form" on your prescription form or letterhead and mail to ICCME, 55 E. Monroe St., Suite 3510, Chicago IL 60603.

**ERRATA**—Two errors occurred in "Evaluation of a Program for Weight Control for Obese Children and Adolescents," by Rajendra Choksi, M.D., Pamela Bunje Bower, A.C.S.W., Vincent Pollard, M.D., and Vipul N. Mankad, M.D., which appeared in our April issue, pages 232-235. The biographical information states that Dr. Pollard is a former clinical instructor for the Loyola University Stritch School of Medicine, a position held through 1960. It fails to state that he is currently a clinical associate professor of pediatrics at the UI Abraham Lincoln School of Medicine. Dr. Pollard further noted that while the fourth paragraph, page 232, states that the therapy group met for two hours each Wednesday afternoon, the group actually met for only one hour.



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Volume 158, No. 1, July 1980

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# Illinois Medical Journal

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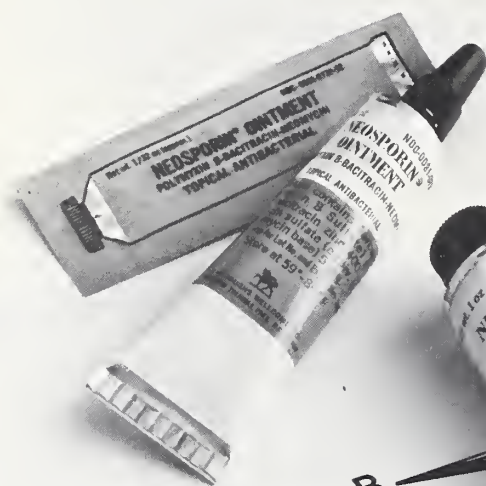
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# IT'S HIGHLY RECOMMENDED... AND FOR GOOD REASONS



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Bacitracin

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Aerobacter  
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Proteus  
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**PRECAUTIONS:** As with other antibacterial preparations,

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**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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# REPORT

## FOR *Illinois Physicians*

### Retiree Gold—A New Service Program for General Motors Retirees

The Chicago-based Blue Cross and Blue Shield Plan, in conjunction with Blue Cross and Blue Shield of Florida and Michigan, General Motors Corporation and the International Union, U.A.W., have developed a new program for improving claims processing methods for General Motors retirees and eligible surviving spouses living in Florida and Michigan. Beginning July 1, 1980, General Motors Corporation hourly and salaried retirees, surviving spouses and their eligible dependents enrolled in Blue Cross and Blue Shield of Florida and Michigan programs will be automatically enrolled in the new Servicing Program and given a new gold-color identification card. This same program will be expanded to include retirees in all other states on October 1, 1980.

Physicians providing service to GM's Gold Card retirees should complete a Blue Shield Physician's Service Report for all services rendered and mail the report to: Health Care Service Corporation, P.O. Box A3957, Chicago, Illinois 60690. After submitting a claim to HCSC, **DO NOT** file a Medicare claim for the same service. Payment will be received from HCSC and will include both the Medicare and Blue Shield allowances.

Since many Florida members previously lived in Illinois and return during the warmer months, we ask your cooperation in ensuring the success of the Program. The distinctive Gold Card should readily identify these members to you. Please honor and accept the Gold ID Card as you do the regular identification card.

There is more than a color difference between the two cards. The retirees' card does not show an effective date of coverage, or a 12-digit service code. The area normally reserved for service code information shows "Auto Retiree Plan."

Benefits for General Motors retirees and servicing spouses have *not* changed, however.

A gold-colored identification card for Blue Cross and Blue Shield of Michigan. It features the Blue Cross and Blue Shield logos on the left. To the right of the logos is a faint map of Michigan. Below the logos are several rectangular boxes for text entry. The first box is labeled "SUBSCRIBER NAME". Below it is a box labeled "GROUP NO". To the right of the "GROUP NO" box is a box labeled "CONTRACT NUMBER". To the right of the "CONTRACT NUMBER" box is a box labeled "B C PLAN CODE".

This Identification Card should be presented to those rendering Blue Cross and Blue Shield covered health care services (hospitals, physicians, medical laboratories, pharmacies, and other health care providers). When a provider submits a local claim form to the local Blue Cross and Blue Shield Plan, payment will be made promptly to the provider, if so designated on the claim form.

Should you be required to file the claim for covered services, send the necessary information to the local Blue Cross and Blue Shield Plan where services were received. Payment will be made to you.

If you or the health care provider need assistance or information about your benefits or claim submission, please contact the local Blue Cross and Blue Shield Plan where services were received. For assistance, including VERIFICATION OF COVERAGE by health care providers, the following TOLL-FREE telephone numbers are available:

Calls Within Michigan  
1-800-482-5980

Calls Outside of Michigan  
1-800-521-5995

2075-0 Mar 80

## Sun Electric Gets Blue Cross and Blue Shield Coverage

The Chicago-based Blue Cross and Blue Shield Plan recently enrolled the Sun Electric Corporation, a nationally known manufacturer of automotive electronic diagnostic machinery and equipment, located in Crystal Lake.

The Plan is providing the 2,600 employees of Sun Electric with a complete benefit program, including Blue Cross, Blue Shield, Major Medical and Dental, along with life insurance and disability income coverage from Fort Dearborn Life Insurance Co.

Among the benefits for the 2,150 non-union employees (Group No. 99059) are:

Lifetime Maximum .....	\$1,000,000
Hospital Benefit Level .....	80%
Deductible Per Calendar Year .....	\$100 Individual/\$200 Family
Semi-Private Room Allowance .....	80%
Private Room Allowance .....	80% of Common semi-private room rate
Medical/Surgical Allowance .....	80% Usual & Customary
Maternity Allowance .....	Same as any other illness
Out-of-pocket Expense Limitation .....	\$500
Out-Patient Mental .....	50/50 up to \$1,000/Calendar Year and \$10,000/Lifetime Maximum
Emergency Accident Care .....	Provided in full

Benefits for the 450 union employees (Group No. 46640) include:

### HOSPITAL BENEFITS

Front-End Deductible Per Admission .....	None
Days of Care Per Illness or Accident .....	365
Room:	
Semi-Private or Ward .....	PROVIDED-IN-FULL
Private Room .....	COMMON SEMI-PRIVATE
Intensive and Special Care Units .....	PROVIDED-IN-FULL
Ancillary Service, Drugs, X-Ray, Operating Room .....	PROVIDED-IN-FULL
Initial visit for Out-Patient Emergency Medical Care and for Accident Care Within 72 Hours of Injury .....	PROVIDED-IN-FULL
Out-Patient Surgery .....	PROVIDED-IN-FULL
Normal Maternity Care .....	Same as any other illness
Hospital Out-Patient Diagnostic Testing .....	\$100/Calendar Year
Psychiatric .....	Provided in full

### MEDICAL/SURGICAL BENEFITS

Surgical Allowance .....	100% Usual & Customary
Surgical Assistant .....	100% U & C
In-Hospital Medical Care for Each Illness or Accident	
365 Daily Visits .....	100% U & C
In-Patient Consultation .....	100% U & C
Physician's Anesthetic Bill .....	100% U & C
Physician's Charges for X-Ray, Laboratory and Pathology .....	100% U & C
Physician's Normal Obstetrical Allowance .....	100% U & C
Physician's Out-Patient Diagnostic Testing .....	\$100/Calendar Year
Supplemental Accident Care .....	\$300
Psychiatric .....	100% U & C

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(This report is a service to the physicians of Illinois)





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# Editorial

## Quality Assurance An Historical Perspective

This month's article by Richard E. Thompson, M.D., entitled "From 'Medical Audit' and 'UR' to Effective Use of Patient Care Data," brings a certain *déjà vu*. Dr. Thompson begins his dissertation by stating that the quality assurance efforts of the '70s were politically motivated, and this is true; however, he should have dropped back into the decade of the '60s to see how we arrived at the motivation of the early '70s. The peer review efforts of the practicing physician through organized medical staffs in the post World War II era served us well in evaluating hospital patient care, through such mechanisms as infectious disease committees, record committees, tissue committees, and the original medical audit efforts. Then we perceived a need to display our efforts in an organized manner so that those other than practicing physicians could be reassured that peer review efforts were meaningful—and we immediately entered into political combat. The battles in the houses of organized medicine resounded with proposals and counter-proposals, supports for and objections against efforts to accomplish this display of concern for the quality care that we, as physicians, have traditionally carried in our profession. In the end, we had a dismal compromise of a political vehicle that started the '70s, now known as PSRO and about which many opinions are held. Concomitant with this mentality, our own standards for accreditation authored by the JCAH were distort-

ed and interpreted by many as "requirements" similar to that the bureaucratic regulation writer promulgates to fill intent of the PSRO ilk.

So, it is refreshing to see Dr. Thompson suggest that the multi-prong efforts of the '70s be brought back to a "phase of development in patient care study methods" that are motivated by the real need for meaningful and valid patient care data. The message that all in the health care system should derive from this is that in our pluralistic system the methods of peer review activity implementation are best developed with consideration of patient concerns in their local environment under the care of physicians sensitive to the pressures of their peers. By so doing we shall accomplish the goals envisioned by Dr. Thompson; impacting on cost because good patient care is cost effective; producing documentation because effective local studies will, of necessity, be documented; and finally provide data that will eliminate the use of allegations, innuendo, and arbitrary accusations frequently heard in the attempt to demean the profession while trying to prove the need for external regulation.

Now that we have come full circle in self discipline, this editor interprets the author's plea for innovation in the use of patient care data to also emphasize the demand that each of us, as physicians, have to become involved in our organized efforts to continue quality patient care. ◀

Robert P. Johnson, M.D.  
Springfield



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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

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**Precautions:** Symptomatic relief should not delay definitive diagnoses or treatment.

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In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

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# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine



**Figure 1**  
This 50 year old man has mediastinal widening.



**Figure 2**  
This 73 year old man has a posterior mediastinal mass.

The radiographic findings in these three patients have a common cause.

## ***How would you further evaluate them?***

- (a) conventional tomograms
- (b) computed tomography
- (c) lymphangiography
- (d) angiography
- (e) no further workup

## ***What's your diagnosis?***

- 1. lymphoma
- 2. aortic aneurysm
- 3. primary neoplasm
- 4. fatty tissue



**Figure 3**  
This 45 year old man has lateral displacement of the left kidney.

*(Continued on page 40)*



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# Guest Editorial

## Physicians, Blood Banking and the Future

This month's issue includes an article which stresses the importance of physician involvement in establishing a workable blood banking system. The physician determines blood need and usage for his patient. He should be at the center of this activity, not on the periphery as in the present system. The ISMS Laboratory Services Committee provides a channel through which solutions to problems encountered are explored.

The article stresses that blood banking problems need to be solved by the private sector in order to avoid possible legislation. Cost, increasing need and consumer awareness issues can be approached through regionalization. If the physician does not participate in these changes, they may be controlled by persons who feel that the physician is "peripheral."

An appropriate perspective incorporates events leading to the present House Human Resource Committee hearing and formation of the Statewide Blood Banking Coordinating Committee. These include the Cunningham decision (1970), and Illinois Blood Labeling Act (HB 4445) of 1972. On a national level, in 1970 the National Academy of Science and National Research Council first described blood banking as a "blood service complex." This included recommendations for unification, standardization and centralization. Also, 1971 Federal legislation called for national blood policy. In 1972, blood was declared a national resource. Public Law 92-423 extended authority of the National Heart and Lung Institute to blood, blood products, blood resources, and development of a national blood program. The Food and Drug Administration is

the regulatory authority. In 1973, a National Blood Policy established four goals, to be implemented by the private sector through the American Blood Commission.

The Illinois Department of Public Health published regulations defining voluntary blood donor and governing unaccredited blood banks. A blood banking task force was established to coordinate a state blood policy for (1) total voluntary blood donation system; (2) unification of pluralistic blood service system; and (3) more equitable needs management for special blood users. The task force was dissolved after addressing only the first goal.

Defects in the current blood banking system include patient satisfaction and the pre-eminent blood service complex concept. The latter view, held by most blood centers, sees blood as a community responsibility in a cascaded hierarchy. The physician enters in later, peripheral stages.

The article proposes that the blood service complex should be a closed circle with physician at center. Patient and physician initiate the process and determine blood service adequacy. The physician can educate the public for donor recruitment and maintain an external audit function.

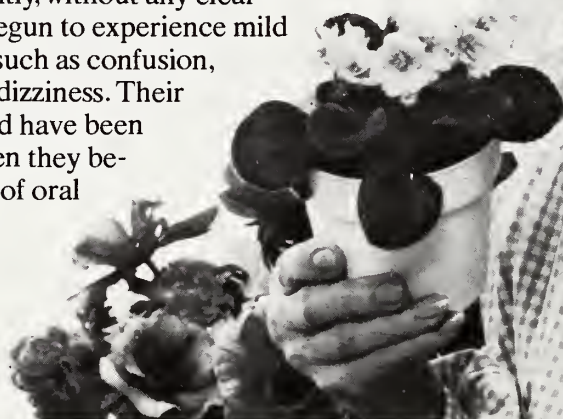
To avoid legislation and develop a workable system, the physician must take a key role in blood banking problems. Viable access is readily available through the Statewide Blood Banking Coordinating Committee. ◀

Richard J. Sassetti, M.D.  
Chicago

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

## Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

**Contraindications:** Hypersensitivity to the drug.

**Precautions:** Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.

**Adverse Reactions:** Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.

**Dosage and Administration:** 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

**How Supplied: Hydergine tablets (for oral use) 1 mg**, packages of 100 and 500.

**Hydergine sublingual tablets 1 mg**, containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg, packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg**, containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg, packages of 100 and 1000.

Before prescribing, see package insert for full product information.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936

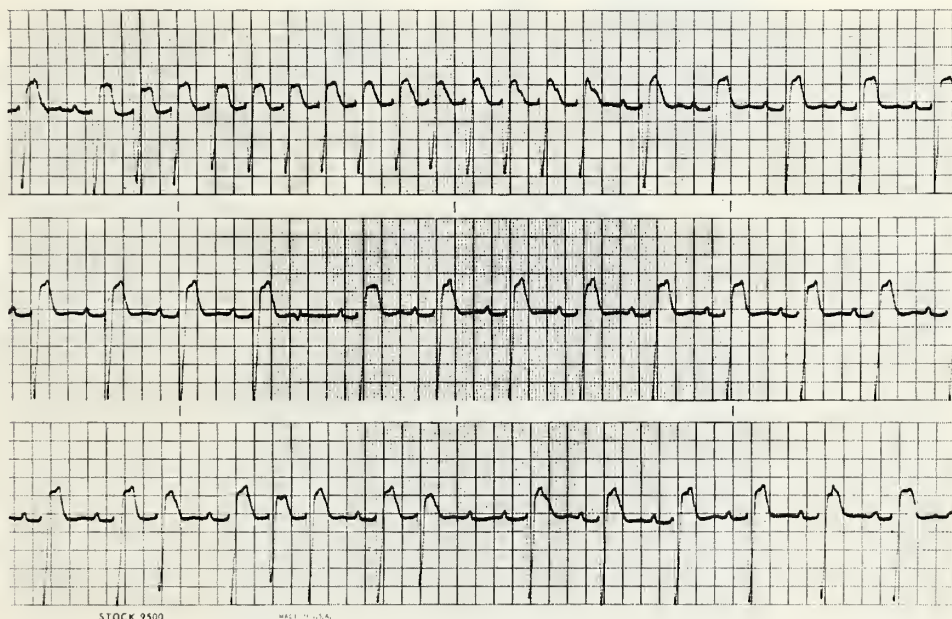




# EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This is a forty-four-year-old patient who had recurrent congestive heart failure for three and a half years. The heart failure followed a massive anteroseptal myocardial infarction. He had no complaints of chest pain; only marked dyspnea on exertion and occasional paroxysmal nocturnal dyspnea. A cardiac catheterization with left ventricular angiography and coronary angiography demonstrated severe left ventricular dysfunction and a totally occluded left anterior descending coronary artery. The right coronary and the left circumflex coronary arteries were normal, although relatively small vessels. He became depressed and presented to the emergency service after taking an overdose of his medications. He took thirty 0.25mg digoxin tablets, twenty 10mg chlordiazepoxide capsules, and sixteen 2mg trifluoperazine tablets. The ECG rhythm strip was obtained because of an irregular heart beat. Intravenous propranolol was given between the first and second ECG rhythm strips.*

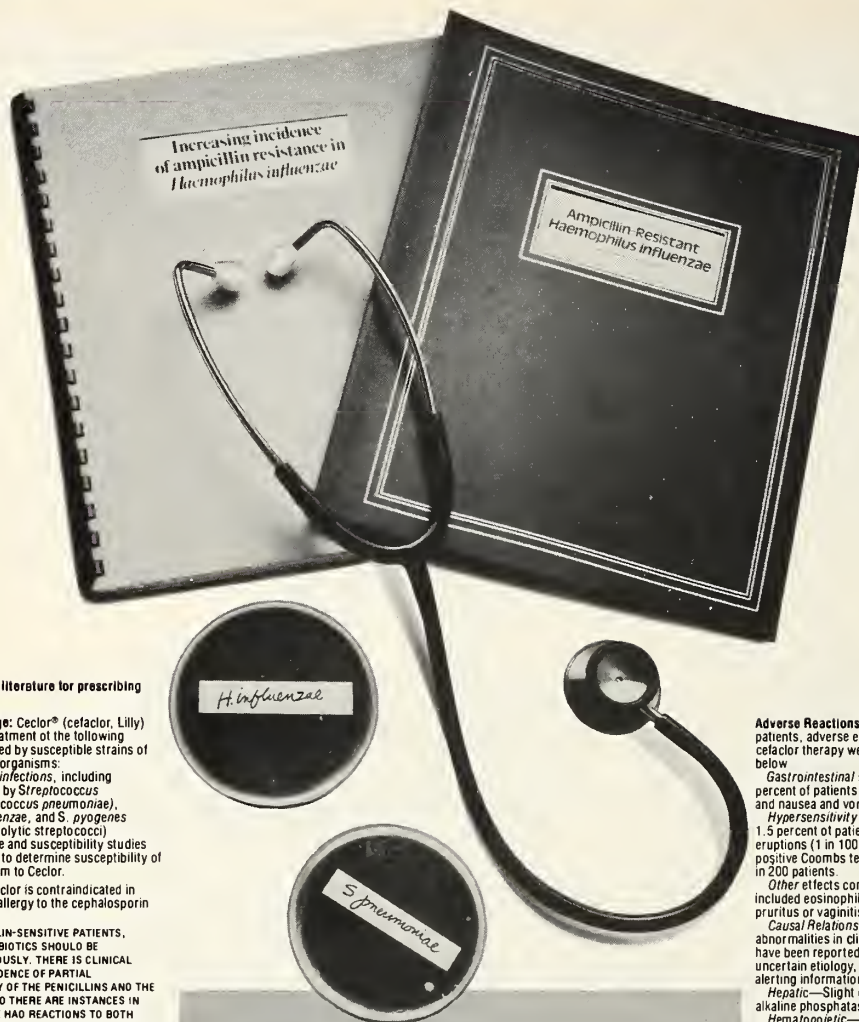


## Questions:

1. The ECG rhythm strip shows:
  - A. Atrial flutter with variable atrio-ventricular (AV) block.
  - B. Atrial tachycardia with variable AV block.
  - C. Sinus tachycardia with AV dissociation.
  - D. Paroxysmal ventricular tachycardia.
  - E. Evidence favoring digitalis toxicity.
2. Treatment for this patient's problem would include:
  - A. Discontinuation of digoxin.
  - B. Propranolol.
  - C. Potassium chloride after a determination of the serum level.
  - D. Direct current countershock or cardioversion.
  - E. All of the above.

(Continued on page 50)

# An added complication... in the treatment of bacterial bronchitis\*



## Brief Summary Consult the package literature for prescribing information.

**Indications and Usage:** Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections,** including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

**Contraindication:** Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

**Usage in Pregnancy:** Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy:** Safety of this product for use in infants less than one month of age has not been established.

**Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefclor.<sup>1-6</sup>**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.<sup>7</sup>

# Cefclor®

## cefclor

Pulvules®, 250 and 500 mg

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefclor therapy were uncommon and are listed below.

**Gastrointestinal symptoms** occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

**Hypersensitivity reactions** were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

**Other effects** considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain:** Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic:** Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic:** Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal:** Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[07037994]

\* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.<sup>8</sup>

**Note:** Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630



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# I M J

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## Hysterectomy: Indications and Contraindications

By PEDRO A. POMA, M.D., F.A.C.O.G., F.A.C.S./CHICAGO

*Gynecological surgery is the most common type of surgery performed in the U.S. During 1975, 6.7 hysterectomies per thousand women were performed in this country.*

*Today, hysterectomies are done more often for functional than simple anatomic indications. This change suggests more patient participation in the decision as to whether hysterectomy should be performed. Hysterectomies are performed on symptomatic or on asymptomatic patients who have conditions that represent potential risk.*

*The choice of the vaginal or abdominal approach is associated principally with training and current preferences of individual surgeon rather than diagnosis. Nationally, less than one third of all hysterectomies are performed vaginally. The morbidity associated with the vaginal approach is higher.*

*The uterus maintains significance to most persons after the reproductive function is concluded. A number of considerations should be evaluated when hysterectomy is considered.*

About half of all persons admitted to U.S. hospitals are surgical patients.<sup>1,2</sup> Lately, the media has blamed the medical profession for performing many unnecessary procedures. Some critics imply that the increased incidence of many procedures

results from a fee-for-service system, not necessarily associated with better health care. Critics often cite statistics from countries with socialized health services. These statistics underline a lower incidence of procedures when possible economic benefits are not derived by the persons who advise or perform the procedures. Obviously, these are not necessarily limited to the surgical field, nor is the performance of a lesser number of procedures necessarily associated with better care for a specific population.

Hysterectomies represent only 2.3% of the 49 million hospital patients admitted in recent years,<sup>1,2</sup> but is among procedures under very close public scrutiny. Most gynecologists are male; this fact has been cited as an explanation for the high incidence of hysterectomies. It is thought that men might not be sensitive enough to be conservative in recommending removal of the uterus.



PEDRO A. POMA, M.D., is a board certified obstetrician and gynecologist affiliated with Cook County Hospital and Mount Sinai Hospital and Medical Center in Chicago. He is a former director of the OBGYN Clinic and a lecturer at the Cook County Graduate School of Medicine. Doctor Poma is also director of OBGYN education of Mount Sinai, where he serves as vice chairman of the OBGYN department.

In addition, Doctor Poma is an assistant professor at Rush Medical College in Chicago, and chairman of the ISMS Task Force on New Health Practitioners.

Table 1  
Rate of Operations—1975\*  
(Number per 1000 Population)

Age	Female	Male
Under 15	28.0	35.0
15 - 44	100.1	42.0
45 - 64	93.6	71.4
65 & OVER	99.4	127.3
All Ages	81.2	53.5

\*Modified from TABLE A, Ranofski, A.L., page 2, 1978<sup>3</sup>

Greed and insensitivity are very serious charges to be leveled against the medical profession and gynecologists in particular. Before we review current accepted indications for hysterectomy, its incidence and changes in patient-physician relationships, which have a definitive influence, will be presented.

### Gynecological Surgery

The most common surgical procedure reported in about 49 million patients<sup>1,2</sup> is curettage (3.5%), followed by tonsillectomy (with a declining incidence in later years). The incidence of hysterectomy is 2.3%, compared with 1.6% for groin hernia repair and 1.4% for cholecystectomy. The incidence of surgery is not disparate among ethnic groups, but varies according to geographic area. These procedures are also more common in larger hospitals (56%) than in smaller ones (45%).<sup>3</sup>

Surgical procedures are more common among women (81.2 vs 53.5/1000).<sup>3</sup> This difference is related mainly to the gynecological and obstetrical procedures. If sex-specific procedures are excluded, surgical rates are almost similar (females: 67.6 vs males: 65.9).<sup>3</sup> Table 1 illustrates the surgical rates in relation to age group and gender. The greater difference between the sexes occurs during the "reproductive years;" 73% of hysterectomies occur in women 31-50 years of age,<sup>4</sup> confirming the statistical influence of gynecological surgery.

Thirty-three percent of the surgical procedures reported from 432 U.S. non-federal, short-stay hospitals were "sex-specific operations."<sup>3</sup> Women had a seven-fold increase of "sex-specific operations" compared to males. Most of the surgery among women (52%) was gynecological, abdominal and orthopedic surgery. Most of the surgery among men (52%) was abdominal, orthopedic and urological surgery.<sup>3</sup> Table 2 illustrates the rate of common gynecological procedures. Even among surgical procedures common to both

TABLE 2  
Gynecological Procedures

Operation	No. per 1000
Diagnostic Curettage	9.0
Hysterectomy	6.7
Ooph/Salpingo-Ooph*	4.4
Sterilization	3.4
Cesarean Section	3.0
Post PG ** Curettage	2.7
Abortion	2.1
Cysto-Rectocoe Repair	1.8

\*OOPH, oophorectomy; \*\*POST PG, post pregnancy

Modified from TABLE H, Ranofski, A.L., page 7, 1978<sup>3</sup>

Table 3  
Operations Performed in Both Sexes  
(Number Per Thousand Population)

Operation	Female	Male
Biopsy	7.0	3.5
Tonsillectomy	3.6	2.9
Cholecystectomy	3.1	1.0
Partial Mastectomy	2.1	0.1
Extraction of Lens	1.8	1.3
Appendectomy	1.5	1.6
Exploratory Laparotomy	1.7	0.9
Urethral Dilatation	1.5	0.9
Hemorrhoidectomy	0.9	1.0
Inguinal Hernia Repair	0.6	4.8

Modified from TABLE H, Ranofski, A.L., page 7, 1978<sup>3</sup>

sexes, the incidence is usually higher among women (Table 3). Once more, the influence of procedures related to the female genital tract is evident: 56% of biopsies performed on women were biopsies of the genital tract.

The rate of hysterectomies (number per thousand women) has not changed during the past several years. But when the 1975 rate is compared to the 1970 rate a 31% increase is noted (Table 4). The rate of female sterilization has more than doubled (112%); cardiac catheterization shows a more marked increase (125%); cesarean section has a 58% increase, curettage 22%, cholecystectomy 19% and prostatectomy 13%. All commonly performed procedures have shown an increase; the rate of curettage will probably continue to increase in this country because it is the most commonly employed procedure for abortion on demand.

### Hysterectomy

The uterus can be excised abdominally or vaginally. Gynecologists would like to be recognized for their performance of vaginal surgery, but the proportion of abdominal/vaginal hysterectomies varies according to hospital and surgeon. Based



**Table 4**  
**Rate of Operations (No. per Thousand Persons)**

Procedure	1965	1970	1975
Curettage*	7.9	8.1	9.9
Hysterectomy	5.2	5.1	6.7
Ooph/Salpingo-Ooph@	3.0	2.9	4.4
Cholecystectomy	2.7	2.6	3.1
Post PG** Curettage	3.1	3.0	2.7
Prostatectomy	2.1	2.3	2.6
Tubal Sterilization	0.7	1.6	3.4
Cesarean Section	1.8	1.9	3.0
Cysto-Rectocele +	1.4	1.4	1.7
Cardiac Catheterization	0.2	0.4	0.9

\*Includes diagnostic and termination of pregnancy

@OOPH, oophorectomy

\*\*POST PG, post pregnancy: puerperal and postabortion

+ Cysto and rectocele repair

Modified from TABLE L, Ranofski, A.L., page 11, 1978<sup>3</sup>

on a recently reported 10-year review of a large teaching hospital, only 33% of the hysterectomies reported were vaginal although a discussant of that report presented a 62.5% vaginal hysterectomy incidence in his practice.<sup>4</sup> Nationwide,<sup>1,2</sup> vaginal hysterectomies represent 30.8% of all hysterectomies. The incidence of the vaginal approach compared to the abdominal is also related to the patient's race: 62% of vaginal hysterectomies occurred in whites; uterine prolapse is more common in whites, while the incidence of myomas is higher among blacks.

At Mount Sinai Hospital of Chicago (from 1975 to 1977) while the incidence of diagnoses that are considered indications for the vaginal approach have increased, the number of vaginal hysterectomies has decreased from 42% to 37%. This decrease has been associated with a less active participation of vaginal surgeons. This would appear to emphasize the definitive influence of individual surgeon preference in choice of vaginal versus abdominal approach.

### Indications

The patient-physician relationship has changed during the past several years, and this change has been more obvious in Gynecology. Most women have become partners in their care and in decision-making process regarding their care. The indications for hysterectomy have become more flexible; while formerly employed for only strict anatomic considerations, hysterectomy has been utilized with increasing frequency to relieve symptoms and also for sterilization.

Since the early 1930's maternal mortality, morbidity and perinatal mortality have continued to

decrease; preventive programs such as prenatal care and cytological as well as hypertension screening have become successful. In addition, contraceptives have become more widely accessible since the early 1960's, and family planning has become an individual right. Currently, patients in increasing numbers come to their physicians' offices requesting specific contraceptive procedures or prescriptions. These requests represent a change in the traditional physician's role as patients request sterilization, abortion, sex-change or cosmetic operations. In addition to psychosomatic illness, there are now more patients visiting physicians' offices who are well and request preventive measures, including those for family-planning. More patients want to be informed about their own bodies and about their own physiology, illness, alternatives with or without treatment, other available treatments and consequences. Most physicians welcome these changes because a well-informed patient cooperates better.

Individual reactions to symptoms vary according to background, their living conditions, day-to-day activities, etc. Minimal pathology or even its absence might produce severe symptoms in some patients, while in others, extreme pathology might produce no symptoms whatsoever. One person's reason for concern represents relief to another, as in the absence or presence of menstruation.

Hysterectomy indications vary in accordance with the individual, her background, her specific circumstances, and those of the persons close to her. It is often cited in defense of the number of hysterectomies that physicians' wives—the informed consumers—have the highest rate of hysterectomy when compared to other groups of women. This fact, the author believes, cannot be generalized; it applies only to physicians' wives. Burchell<sup>5</sup> believes that women are less concerned about unnecessary hysterectomies as defined by others than they are about unwanted hysterectomies as defined by themselves.

A hysterectomy is performed on a symptomatic patient or on an asymptomatic patient who harbors a condition that represents a risk to her. The possibility of pregnancy should always be considered during presurgical evaluation. A colon-X-ray and intravenous pyelogram may be required, as may other tests, to evaluate concomitant medical and surgical conditions. A recent cervical cytological smear result should be available.

### Does She Need A Hysterectomy?

Table 5 lists indications for hysterectomy from the physician's point of view. The long term emo-

**Table 5**  
**Indications**

**Absolute—Desirable—Debatable**

tional sequelae commonly associated with hysterectomy are less significant among patients with absolute indications who understand and accept the need for this life-preserving measure.

The specific category of indications varies with time and location. Surgical indications sometimes diminish when pathophysiology is better understood, as with abnormal uterine bleeding (an endocrine disorder), pelvic congestion and pelvic pain (with strong psychosomatic and psychosexual components which should be effectively evaluated).

Table 6 lists common accepted indications for hysterectomy. Seventy-seven percent of hysterectomies are due to myomas, adenomyosis and endometriosis; malignant disease represents only 9%.<sup>4</sup>

In a nationwide statistical analysis<sup>1,2</sup> uterine myomas represent 0.7% of all the discharge-diagnoses, uterovaginal prolapse 0.8%, metrorrhagia 1.2%, fibrocystic disease of the breast 0.7%, endometriosis 0.3%, invasive neoplasia of cervix, corpus and ovaries 0.4%, and carcinoma of the breast 0.5%.

Uterine myomas *per se* do not constitute an indication for hysterectomy (myomas usually regress after menopause), unless the uterine size is larger than a 12-week pregnancy (interfering with the evaluation of adnexal area; an ovarian malignancy cannot be ruled out) or if myomas suddenly increase in size (possibly a malignant change), or unless the myoma is causing metrorrhagia and anemia (anemia might be prevented with hormonal therapy or corrected with iron therapy in preparation for surgery), or there is pelvic pain and pressure, which may be associated with rapid tumor growth.

Myomas are not necessarily associated with infertility. Myomectomy, although it is not done as often now, is indicated in selected patients when tumors cause discomfort. Myomectomies should not be performed on patients whose tumors are growing fast. The procedure can never be promised to the patient, because unsuspected adnexal pathology may be found; technical difficulties may be encountered due to tumor location, and possibility of diffuse leiomyomatosis prevents conservative surgery.<sup>6</sup> Fertility nor-

**Table 6**  
**Indicators**

1. *Inherent disease in the uterus*  
(leiomyoma, adenomyosis, endometriosis, premalignant conditions)

2. *Adnexal pathology*  
(Ca ovary, tube; colon. PID. Post-menopausal with undetermined adnexal mass)

3. *Trauma*  
(Ob rupture, uncontrollable puerperal bleeding; abruptio, accreta. Septic AB, necrosis of the myometrium)

mally decreases after 35 years of age, and the incidence of mental retardation in the offspring begins to increase. Thus, myomectomy should not usually be performed in women older than 35 for fertility reasons.

The author employs a No. 12 foley, with a 5ml bag inflated in the uterine cavity to facilitate the injection of diluted indigo carmin as a test for tubal patency during myomectomies and also to be certain tubal lumen is not encroached on during repair of the myometrium. Consideration of the desire for more children is essential during these discussions with the patient, and this information can be applied to most of the listed indications for hysterectomy.

Hysterectomy for sterilization has become a more "accepted" procedure than it was in the past. This attitude represents a more open and honest approach to an indication which has been present for many years. In the past, different reasons and diagnoses may have been utilized to provide clinical criteria for sterilization. But hysterectomies in general carry a higher risk of mortality or morbidity than simple sterilization. Thus, the trend toward increased hysterectomies for sterilization has been abandoned in hospitals where sterilization can be performed and by surgeons who perform them. Both female and male sterilization have also become more readily available. This trend has been facilitated by the opening of many surgical ambulatory centers. Nevertheless, one must remember that tubal sterilization is associated with late sequelae and hysterectomy should probably be considered for any patient requesting sterilization who already has menstrual irregularities, pelvic pain, myomas and borderline cytology.<sup>7</sup>

#### **Indications For The Abdominal Approach**

—*The need for abdominal exploration* (when concomitant abdominal pathology is present in



**Table 7**  
**Hysterectomy Approach**

*Abdominal*

- Need for abdominal exploration
- Orthopedic and vascular problems
- Contraindications to vaginal approach

*Vaginal*

- Experience
- Uterine Prolapse
- Preinvasive Carcinoma

cases where repair of the pelvic floor is also needed, a combined abdominal vaginal procedure is indicated.)

—*Orthopedic problems* (low back and extremities) which prevent patient positioning for the vaginal approach.

—*Adnexal mass of uncertain etiology and any suggestion of invasive malignancy* (with incomplete evaluation.)

—*Contraindications to the vaginal approach*, especially the narrow sub-pubic angle which would limit the vaginal approach. There are other relative contraindications to the vaginal approach, such as uterine size, previous pelvic surgery, chronic pelvic inflammatory disease and adnexal pathology. These contraindications are related to individual surgical experience. But most surgeons will not remove a uterus larger than 12-week size per vagina, although morcelation techniques which facilitate the removal of a large uterus have been described.<sup>8</sup>

Joel-Cohen<sup>9</sup> considers previous abdominal surgery as an indication for the vaginal approach, especially if the previous surgery was associated with peritonitis or intestinal obstruction, with the common findings at later surgery of multiple bowel adhesions (to the abdominal wall, to another bowel loop, to the omentum and to the uterus) which is associated with a stormy post-operative course because of the amount of bowel manipulation.

### Indications For The Vaginal Approach

—*Obesity* (less complications are reported compared with the abdominal approach.)

—*Symptomatic uterine prolapse*, when accompanied by cystocele and rectocele. These findings increase with age and are associated with obstetrical trauma, but the individual predisposition is important. Uterine prolapse may occur at any age; occupations that determine a constant increase of the intra-abdominal pressure may

contribute to this problem. Uterine procidence is more commonly associated with advanced age. It is not necessarily easier to remove a uterus which is totally prolapsed; the ureter and the bladder might also be included in the descent and the anatomic references are distorted.

—*Symptomatic cystocele and rectocele*. The recurrence rate appears to be lower when hysterectomy is performed.

—*Stage 0, carcinoma of the cervix*. The diagnosis is usually established by colposcopy examination or cone biopsy. About 4% of patients present a squamous - columnar junction outside the portio-vaginalis and a partial vaginectomy may be required when colposcopy has assisted the identification of the squamous-columnar junction.

### Disadvantages of the Vaginal Approach

—*Development of enterocele with or without vaginal prolapse* occurs in as many as 8.5% of patients following vaginal hysterectomy.<sup>10</sup> This condition sometimes occurs as early as 6 weeks post-surgery. But this complication is preventable.

—*Postoperative morbidity following vaginal approach* is higher. Febrile morbidity occurs in 26% of patients after vaginal hysterectomy compared to 16% incidence following abdominal hysterectomy.<sup>4</sup> Bleeding incidence was also higher following vaginal surgery (2.6%) compared to 0.9% incidence after abdominal hysterectomy.<sup>4</sup> The occasional fallopian tube prolapse is more common following vaginal hysterectomy, probably because the pedicles are often brought to the cuff.

Careful closure of the cuff with approximation of the utero-sacral ligaments reduces the incidence of enterocele. The use of prophylactic antibiotics and adequate drainage of the vaginal cuff (employing a T-tube) decreased morbidity following hysterectomy, and the differences between the abdominal and vaginal approach are reduced.

### Contraindications To Hysterectomy

The contraindications listed in Table 8 can be evaluated with adequate history, physical examination, and ancillary tests. During the interview the surgeon should also be aware of the patient's feelings, desires and beliefs. This consideration brings us to counseling for hysterectomy.

### Preoperative Counseling

The uterus is not a dispensable organ. Hysterectomy is commonly associated with emotional sequelae.<sup>11</sup> The uterus has more associated functions than are clinically recognized. The uterus

represents femininity, motherhood and sexuality. This attitude is shared by both men and women of all sophistication levels and can hardly be changed by a brief interview.<sup>12</sup> The preoperative discussion, which should include the spouse, must involve all of these ego-threatening possibilities. The couple's and especially the patient's wished for additional children, the reassuring effect of menstruation, the woman's psychological

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**Table 8**  
**Contraindications**

*Physician*

- Unfamiliarity with the attempted approach or patient
- Uncertain diagnosis
- Incomplete evaluation of invasive carcinoma

*Patient*

- Desire for larger family
  - Psychological (fears, sexual, depression)
- 

attitude toward surgery, and the couple's beliefs regarding the supposed effects of hysterectomy should all be considered and discussed. The patient should be allowed to express her feelings. The possibility of a hysterectomy represents at least a triple threat to her: the threat to life (the disease that requires the surgical procedure and its prognosis), the threat of surgery (hospitalization, anesthesia, bodily harm) and the threat of losing her uterus (altering self-image).

Often the patient and even the partner may appear not to react (at least not unfavorably), and this attitude may be interpreted as one of compliance or understanding. However, the patient is probably trying to cope and adjust to the whole process. Her reaction will depend upon her background and how well she has previously managed similar stressful situations. At Mount Sinai Hospital-Chicago, all these steps are repeated the night before surgery. This program includes a short movie about the procedure that stimulates conversation and discussion among patients and also encourages them to ask personal questions in private. Only when the counselor is satisfied that the patient completely understands—when she can repeat the facts in her own words—is the counseling concluded.

Depression is a common reaction following hysterectomy,<sup>11,12</sup> and this depression can be alleviated by adequate counseling. This at least

will assure the patient that we have an open attitude for further discussion. Probably, we still do not have all the evidence about the influence of the uterus on the general well-being of a woman. For example, we commonly believe that a hysterectomy should not have any deleterious effects upon the patient's sexuality, that all fears are only myths and probably only exist in the patient's and her partner's imagination, despite the classical work of Masters and Johnson that demonstrated the active participation of the uterus during the different phases of the female sexual cycle. Furthermore, the importance of the uterine mobilization (propioception) for the woman and her partner during vaginal penetration has not yet been evaluated. This factor might have emotional and fantasy components.

Obviously, patient participation during the process of diagnosis and decision-making in regard to hysterectomy will ameliorate later possible inappropriate reactions, while monthly evaluation of hysterectomies performed by members of the hospital's Obstetrics and Gynecological Departments will also contribute to the elimination of unnecessary procedures. ◀

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## Seven Suggestions For Getting There

# From "Medical Audit" And "UR" To Effective Use Of Patient Care Data

BY RICHARD E. THOMPSON, M.D./OAK BROOK

*How should quality and cost effectiveness of patient care services be measured? What review methods are fair, feasible, and effective? How should findings be used? Nobody yet has all the answers. But the "audit" and "UR" phase of the 1970's produced several advances in patient care study methods. (Table 1) Several needs must next be acknowledged and addressed by both regulators and researchers.*

### 1. The need for external requirements that encourage evolution of more effective patient care study methods

The modern patient care evaluation era, 1970-1978, has been marked by frantic scrambling to meet requirements of the Joint Commission on Accreditation of Hospitals<sup>1</sup> and Professional Standards Review Organizations (PSRO's).<sup>2,3</sup> The specificity of JCAH/PSRO requirements has raised some eyebrows, considering lack of evidence confirming effectiveness of specifically required methods.<sup>4-6</sup>

Detailed requirements have actually been a two-edged sword. Unless forced to try *something*, we might not have realized that available methods were neither effective enough, efficient, or accurate and fair. On the other hand, rigid requirements have discouraged innovation.

Requirements of external agencies will continue

to be a major influence on patient care study methods. The standards and requirements of JCAH, PSRO, and any new quality assurance arms of HSA's, HMO's or National Health Insurance must encourage innovative study methods and more imaginative uses of results. If requirements remain rigid they will delay, rather than hasten, effective use of valid patient care data.

### 2. The need to consider new uses for patient care data

"Quality Assurance," "retrospective medical audit," and "concurrent UR" were considered bold innovations as recently as five years ago.<sup>7</sup> Now they have about run their course, because the light of our increased sophistication reveals them to be procedures of limited scope and questionable effectiveness.

"Audit" and "UR" are victims of their own restrictive view of potential uses for patient care data. UR requirements emphasized the limited objective of certifying necessity of services for third-party payers. Length of stay was the only parameter used in the review process. (Reviewing necessity of admitting the patient at all has been much discussed, but never effectively implemented.) "Medical audit" requirements have influenced a limited focus on finding "deficiencies" and taking "corrective action."

Because of pre-occupation with these precise and specific emphases, numerous other uses of valid patient care data await wider recognition.

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**Table 1**  
**Changes In Concepts And Methods Of Patient Care Review**  
**(Audit And UR)**

1970	1978
1. Physicians review physician performance.	1. All patient care disciplines review their respective roles in patient care.
2. Review findings are used to force physician compliance with the "norm".	2. Patient care study findings are used in many ways to confirm and/or improve institutional and individual performance.
3. Emphasis on external review.	3. Emphasis on internalization of the review process with external regional monitoring.
4. Expectations (criteria, standards) stated in terms of specific patient management protocols.	4. Expectations (criteria, screening indicators) stated in terms of results and goals of patient care, allowing variations in specific patient management protocols within acceptable clinical limits.
<p><i>Example:</i> If diagnosis is peptic ulcer—Were history, physical, upper GI X-ray, gastric analysis, and gastroscopy done?</p>	
5. Attempt to determine whether retrospective or concurrent review is the procedure of choice.	5. Relate, don't debate. Retrospective review methods determine patterns, and concurrent monitors confirm implementation of needed improvements.
<p><i>Example:</i> If diagnosis is peptic ulcer—Was diagnosis confirmed by X-ray or gastroscopy findings, or by a stated combination of history, physical and laboratory findings?</p>	

Already, numerous patient care studies ("audits" or "medical care evaluation studies") contain valuable findings which have been overlooked because they could not really be classified as "deficiencies," and uses of the findings would be neither "corrective action" nor related to reimbursement.<sup>8</sup>

Thus, it would be a major mistake to assume that the declining image of "audit" and "UR" implies a declining need for valid patient care data. At this writing, fashionable buzz words in the health care field include "cost containment," "risk management," "continuing education," and "rate review." The buzz words will change. But the need for valid patient care data to guide our consideration of any health care issue will remain. For example, the present approach to decreasing utilization of unnecessary services is government pressure. A better approach is using valid patient care data to show practitioners (and attorneys) that some services can be cut without an accompanying decline in baseline quality care parameters.

Table 2 lists ways in which patient care study findings have already been used by imaginative health professionals.<sup>9</sup> The list grows constantly. Consideration of such uses must impact on the systems design and organizational place of patient care study activities. Ideally, JCAH/PSRO requirements would demand effectiveness in these areas, allowing flexibility as to how this effective-

ness is (a) achieved, and (b) confirmed.

### 3. The need to agree on a simpler, clearer vocabulary

This article is hard to write simply and clearly, because the available vocabulary is complex and confusing.<sup>10</sup>

Reviewing patient records using criteria may be referred to as audit, medical care evaluation, or patient care evaluation, and is considered one form of peer review. But peer review can also mean reviewing questionable claims for third party payers, or sanctioning a fellow physician for allegedly poor practice habits.

There is a difference of opinion about whether "concurrent audit" is wise. But one discussant may mean concurrent collection of data for retrospective analysis, while the other is referring to concurrent enforcement of a standard. A "standard" may refer to a plan of clinical management considered superior to other plans of clinical management (optimal practice), a number between 0 and 100 with a percent sign by it (normative practice), or a JCAH requirement. Then there's always the opportunity to confuse "concurrent audit" with "concurrent monitoring," which is not exactly the same as "concurrent review," but a lot like it.

Red flag words abound. "Audit" is a good example. Those who framed the term refer to the



**Table 2**  
**Some Uses For Patient Care Study Findings<sup>9</sup>**

1. Validate criteria and standards by relating processes of care to whether or not goals of care are met.
2. Provide relevant continuing education activity.
3. Assist planning.
4. Improve the quality of patient records.
5. Demonstrate continued competence. Relate to periodic renewal of clinical privileges.
6. Improve performance of support services, such as laboratory and radiology.
7. Save physician time by assuming many chart review functions of traditional medical staff committees.
8. Reduce risk of legal liability by documenting and improving professional and institutional performance.
9. Use for case-finding, *e.g.*, need for discharge planning seen in reasons for "over-stays."
10. Measure and/or predict impact of regionalization and planning activities on individual patient care results.
11. Satisfy accountability to (and of) governing board.
12. Focus concurrent monitoring on identified problem areas.
13. Increase communication among patient care disciplines.
14. Compare own experience with "the literature."
15. Obtain and retain delegated review status under PSRO.
16. Meet JCAH quality assurance requirements.

Latin root word *audire*: to hear.<sup>11</sup> Unfortunately, this word does not provoke such scholarly thoughts in most of us. We have encountered "audit" in unpleasant contexts, *e.g.*, "I hope they don't audit my tax return." Thus, we are likely to assume that "medical audit" is completely related to the finances of care, and/or that it should be conducted in a punitive manner.<sup>12</sup>

Meanwhile, the term "quality assurance" has been used to describe everything from saving money to measuring patient care effectiveness to naming a specific American Hospital Association program.<sup>7</sup>

The headlong rush to evolve a review "system" must pause long enough to clarify meanings of commonly used terms. (A "system," by the way, can be anything from a list of procedural steps to a commercially available data processing panacea.)

Activities tend to assume the characteristics of the words used to describe them. Those who say there should be less emphasis on "medical audit," in the negative sense, are correct. Use of positive, clearly descriptive terms which remove the implied threat of "audit" hastens acceptance and proper use of study findings. Several hospitals no longer have "Audit Committees" to identify "deficiencies" and take "corrective action." They have multidisciplinary clinical department "study groups," whose findings are used in a variety of ways to educate, increase awareness, assist communication, and improve policies and procedures

(Table 2). Sanctions are reserved for individuals unresponsive to initial positive approaches, and whose habits of care have clearly injurious consequences.

#### **4. The need to define "quality patient care"**

If you dare ask, "What is quality?" you are likely to be viewed as a hopelessly bewildered individual. The answer may be, "Never mind trying to define it; just go measure it." This answer may, in fact, be used to mask our inability to come to grips with what really is a good question.

The need is not for a dictionary definition, but for a "working definition," specific enough to guide us in the design and use of our patient care study procedure. For instance, quality patient care can be defined as including at least five aspects:<sup>10</sup>

- Optimal, achievable result for each patient.
- Avoidance of iatrogenic complications.
- Attention to the patient's needs as a person.
- Effective patient education.
- Utilizing the most cost-effective diagnostic and management plan to meet these objectives.

Using this working definition of quality, it is possible to check the completeness of study procedures. Patient care studies should be designed to collect information relating to each of these concerns. Interpretation and use of findings should acknowledge each factor. Note that an appropriate relationship between "quality" and "cost" concerns emerges from the use of this definition.

#### **5. The need to relate data collection and display systems to the purpose for which the data is being collected and displayed**

Many data processing systems which purported to assist the quality review process came and went during the 1970's. Some of these systems seemed based on the assumption that data collected and displayed for one purpose are equally useful for other purposes. It was a long, painful process to learn that this assumption is incorrect. For instance, consider this statistic: 71% of patients admitted to the hospital have rectal examinations. No method of interpreting this statistic will answer the key "quality care" question: Did we perform this procedure when indicated, such as to rule out prostate cancer in a male patient over 40, and avoid it when it was contraindicated, such as if the male patient over 40 had chest pain suspicious of heart attack?

On the other hand, this statistic is quite useful if the question is: "How many rectal gloves should the Administrator order next month?"

Another mistaken assumption has been that collecting data on 100% of patients is necessary for all purposes. A 100% sample is necessary when data are used to develop epidemiologic summaries, total costs, or incidence figures. But determining effectiveness and necessity of medical services requires in-depth investigation of patient care encounters. Such a study procedure on all patients is neither feasible nor necessary. Appropriate sample size and sample selection methods are key questions which have great impact on the efficiency and economic feasibility of patient care review systems.

Most importantly, development of complex data processing systems sometimes proceeded without adequate validation of clinical assumptions. The result was a paradox. Much unneeded data was abstracted and displayed, without collecting what was really needed.<sup>13</sup> Sometimes, data systems depended for "physician input" on people who possessed an M.D. degree, but had no experience as a physician. For example, produc-

tivity figures quoting "cost of typical appendectomy" will be grossly misleading if they are based on the assumption that every such patient requires an upper GI series and a barium enema, which is clinically wrong.

The single most important question for designers of data systems to consider is: "What tests of *clinical* validity must be included, along with tests of data abstracting, accuracy, and statistical reliability?"<sup>14</sup>

Computers may be used to establish and store blueprints for modern housing. But if you drive by a construction project, you will note that there is still no better way to turn the plan into a building than brick-by-brick, laid one at a time, by individuals using specific manual skills. Review of individual patient records by clinicians should remain the "brick-by-brick" validation component of patient care review systems.

#### **6. The need to avoid complex devices in review methods**

Evaluating patient care is hard enough without introducing needless complexities. Don't misunderstand this point. Standard protocols for data retrieval and display are necessary so that information is valid, reproduceable, and accurate. But complex protocols discourage much-needed interdisciplinary communication between clinicians and systems designers.

A specific example of a complex protocol is the "0/100% + Exceptions" convention introduced in JCAH's PEP system.<sup>15</sup> This device was intended only as a data retrieval (abstracting) convention, not a "clinical standard." But unless you are an expert at "speaking audit," you may have trouble understanding this distinction.<sup>16</sup> I am certainly having trouble giving a brief, concise explanation. At the very least, we are both being distracted from the clinical review process by the necessity to understand a complex device, which necessitates (a) unique definitions of four terms: criterion, element, exception, and standard (b) complex worksheets or audit forms and (c) a reversal in the clinician's thought process. (Clinicians will tell you that "all or nothing" is nonexistent in clinical medicine. As a more cautious clinician, I would only tell you "all or nothing" is so rare that I can't think of any unassailable examples.)

The complex convention can be avoided. Consider the criterion shown in Table 3.

There are probably several alternatives to the "0/100% + Exceptions" convention. That shown



**Table 3**  
**CRITERION<sup>17</sup>**

Element	Standard	Exception
Endotracheal Intubation	0%	A. Arterial PO <sub>2</sub> less than 60mm. Hg on 100% O <sub>2</sub> . OR B. Apnea

The purpose of this criterion is:

- (1) To develop data about the incidence of endotracheal intubation in hyaline membrane disease and
- (2) To screen records of intubated patients for the presence of either of the two stated indications.

The same objectives can be accomplished by converting the "criterion" to plain English:  
IF endotracheal intubation was done,

THEN either

- (A) arterial PO<sub>2</sub> less than 60 on 100% O<sub>2</sub>, OR
- (B) apnea.

The following "made-up" data might result from using either "criterion model":

Endotracheal intubation: 4/50 (8%)

- (A) 1
- (B) 1

Charts for committee review: 2 (#12695 & #13684)

(4 of 50 HMD patients were intubated; 1 for low PO<sub>2</sub>, 1 for apnea. The other two charts must be reviewed by the committee to see WHY<sup>18</sup> intubation was performed, in the absence of one of the two stated indications.)

in Table 3 is discussed because (a) it eliminates the need to learn to "speak audit" (b) complex forms are not required (c) it is in line with, rather than contrary to, the clinical thought process (d) we pick up a bonus - computer language, allowing construction of decision tables and facilitating communication between clinicians and systems designers.

Flexibility is again important. Those who are comfortable with the "0/100% + Exceptions" criterion model should continue to use it. Those who wish to consider an alternative method of accomplishing the same purpose should be allowed to experiment.

#### **7. The need to incorporate appropriate input from patients and their families**

Patient care evaluation is really the study of how well we are meeting patient care goals.<sup>19</sup> But so far, goals of care are established solely from the viewpoint of the provider. And studies of care are designed and interpreted by providers, without opportunity for comment by representatives of the public. Several providers of

care, forced by illness or injury to become patients, tell us that provider's views are often incomplete.<sup>20,21</sup> Consumers agree.<sup>22</sup> The following examples illustrate how studies done by providers might be altered with patient/family input. These examples are results of early work of the Illinois Hospital Association's Committee on Patient Expectations and Perceptions:

#### **Example 1:**

A multidisciplinary Emergency Room audit/MCE committee screened records to see if patients were "seen by *either* (a) E.R. Physician or (b) E.R. Nurse, or (c) resident physician." All E.R. records reviewed satisfied this indicator.

However, when recovered myocardial infarction patients and their families were interviewed about their E.R. experience, several suggested that the persons in charge of their care at such a crucial time should identify themselves as to position and qualifications.

Absent patient and family input, the provider study missed an opportunity to con-

sider adopting a simple procedure (identify yourself to patient and/or family) that could go far toward improving the public image of E.R. care.

#### Example 2:

The same interviews with post-MI patients revealed that some patients and families expected the attending physician and the consulting cardiologist to be waiting for the patient at the E.R. door. Providers do not consider this a reasonable expectation. Marcus Welby is unreal. Physicians don't have the luxury of dealing with only one patient at a time.

Clarifications of such points between patients, E.R. personnel, attendings, and consultants may be the most effective approach to reducing the incidence of malpractice suits.

Representatives of the public chosen to be partners with patient care providers in studying patient care should have a reputation for objectivity and fairness. "Public participation" need not mean submitting to demands of organized consumer groups with specific axes to grind.

#### Summary

Quality assurance efforts of the 1970's were politically motivated. The next phase of development in patient care study methods should be motivated by real needs for more meaningful and valid patient care data. Needs include flexible standards, expanded and imaginative uses of patient care study data, a concise vocabulary, a definition of what we are attempting to measure, appropriate designs of data collection and display related to planned uses of the data, avoidance of needlessly complex conventions, and public participation in review activities.

Patient care review activities need not be a negative policing procedure directed against providers. Valid patient care data can assist health professionals in such ways as (a) insisting that arbitrary cost cutting decisions consider anticipated and/or observed impact on quality parameters, (b) providing a documented basis for insisting on improved performance among peers, and (c) confirming that arbitrary accusations of poor quality and/or needlessly expensive hospital care are often unjustified. ◀

#### Addendum

On April 7, 1979, the Board of Commis-

sioners of the Joint Commission on Accreditation of Hospitals replaced the restrictive "numerical medical audit" requirement with a "quality assurance standard" requiring "innovative" and "flexible" study methods, plus "integration" and "coordination" of existing quality assurance activities.

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# Obituaries

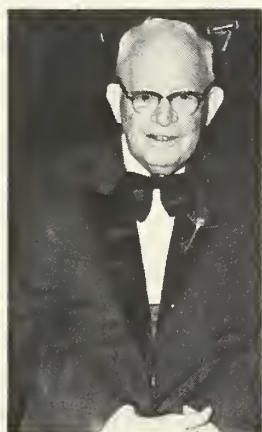
\***Aavik O. R.**, Bloomington, died June 2, 1980, at the age of 60. Dr. Aavik was a 1949 graduate of Tubigen Medical School in Germany.

\***Brosnan, John J.**, Chicago, died January 21, 1980, at the age of 66. Dr. Brosnan was a 1940 graduate of Loyola University Stritch School of Medicine.

\*\***Coleman, Everett**

**Porter**, Canton, died June 11, 1980, at the age of 88. Dr. Coleman, the only ISMS President to

serve for two successive years (1945-46) joined the Fulton County Medical Society in 1921. A fellow of the American College of Surgeons, Dr. Coleman was a founder and former president of the Illinois Surgical Society. Well known for public service and devotion to his profession, Dr. Coleman also helped to found the Fulton County Health Department. He was elected Alumnus of the Year by the UI Medical School Alumni Association in 1972, and had been named Canton's Man of the year in 1969. Dr. Coleman was also a former president of the Western Surgical Society, the Mississippi Valley Medical Society and the American Railway Surgeons. Dr. Coleman had served as chief of staff at Graham Hospital in Canton, and memorials may be made to the Graham Hospital building fund.



\***Collins, John M.**, Belleville, died April 25, 1980, at the age of 65. Dr. Collins was a 1941 graduate of Northwestern Medical School.

\*\***Coppock, Orion O.**, Chicago, died May 6, 1980, at the age of 85. Dr. Coppock was a 1923 graduate of Emory University.

\*\***Davia, James E.**, Maywood, died March 19, 1980, at the age of 74. Dr. Davia was a 1930 graduate of the University of Illinois College of Medicine.

\***DeYoung, Willard G.**, Chicago, died March 21, 1980, at the age of 72. Dr. DeYoung was a 1936 graduate of the University of Chicago Pritzker School of Medicine.

\***Duggan, William E.**, Des Plaines, died June 3, 1980, at the age of 47. Dr. Duggan was a 1958 graduate of the Loyola University Stritch School of Medicine.

\***Erlandson, Lawrence Joseph**, Wilmington, died May 18, 1980, at the age of 75. Dr. Erlandson was 1935 graduate of the Northwestern University Medical School.

\***Freeman, Bernard S.**, Park Ridge, died May 5, 1980, at the age of 66. Dr. Freeman was a 1939 graduate of the Chicago Medical School.

\***Hall, John B. Jr.**, Chicago, died April 28, 1980 at the age of 73. Dr. Hall was a 1931 graduate of the University of Pennsylvania School of Medicine.

\***Hoffman, Frederick A.**, Chicago, died May 13, 1980 at the age of 85. Dr. Hoffman was a 1922 graduate of Westfalen University, Germany.

\***Krolkowski, John R.**, Chicago, died April 27, 1980, at the age of 63. Dr. Krolkowski was a 1943 graduate of the Chicago Medical School.

\***Lipton, Saul I.**, Danville, died May 1, 1980, at the age of 71. Dr. Lipton was a 1937 graduate of the University of Paris, France.

**Patterson, Virginia N.**, Wheaton, died March 5, 1980, at the age of 62. Dr. Patterson was the Chief of Nuclear Medicine of the University of Illinois.

\***Platt, Alfred J.**, Chicago, died June 4, 1980, at the age of 72.

\***Richter, Harry M., Jr.**, Constance, died April 20, 1980, at the age of 63. Dr. Richter was a 1941 graduate of the Northwestern University Medical School.

\***Rokita, Adam Walter**, Quincy, died March 11, 1980, at the age of 71. Dr. Rokita was a 1937 graduate of the University of Michigan Medical School.

\***Quinn, James Leland**, Chicago, died April 28, 1980, at the age of 47. Dr. Quinn was a 1929 graduate, Bowman Gray School of Medicine, Lake Forest College, Winston-Salem North Carolina.

\***Romano, John Emil**, Oak Park, died April 8, 1980, at the age of 71. Dr. Romano was a 1935 graduate of the Loyola University Stritch School of Medicine.

\***Smith, R. Glenn**, Rockford, died May 5, 1980, at the age of 69. Dr. Smith was a 1938 graduate of University of Oklahoma School of Medicine.

\*\***Strauss, Siegfried F.**, Chicago, died April 17, 1980, at the age of 85. Dr. Strauss was a 1926 graduate of the Northwestern University Medical School.

\***Zekas, John Stanley**, Chicago, died May 28, 1980, at the age of 73. Dr. Zekas was a 1935 graduate of University of Wisconsin Medical School.

\* Indicates ISMS Member

\*\* Indicates ISMS member of the fifty year club

# Special Articles

## Physicians, Blood Banking, and the Future

BY RICHARD J. SASSETTI, M.D./CHICAGO

Over the past several years, healthcare delivery has been greatly influenced by sophisticated, complex and costly diagnostic and therapeutic modalities and the cadre of specialists necessary for their effective application. An inevitable concern has come with these new modalities within the medical community for efficacy and cost effectiveness and dilution of the primary physician's control of medical care.

Concomitantly, with equal force, the delivery of medical care is being molded by pressures outside the medical community. Increasing consumer awareness, spiraling costs and a desire to arrive at a "single standard" for the entire citizenry has led to increasing surveillance by outside agencies.

Social pressures mandate approaches toward effective balance of all factors influencing cost and availability of medical care.

In the past, solutions to specific problems were often marked by compromise; to achieve high quality, one accepted high costs. If necessary, to achieve ready availability one accepted inefficiency. This approach did accomplish the goals of

high quality medical care but often led to a double standard of service.

Regionalization is frequently espoused as the optimal compromise. Emphasis is given tangible effects, such as dollar or manpower savings, which are easily defined, understood and quantified. Intangible or peripheral effects are either rendered speculative or left to experience and as a result are defined only *post facto*. This can result in deficient planning with attendant undesirable results which then are termed inevitable.

Medicine will likely be pressed into regionalization for which planning is far from complete and in which important issues may be ignored or viewed as peripheral. The facet of medical care now at risk is blood banking and the issue which may be considered peripheral is physician involvement.

Hemotherapy has had its share of new, complex, and costly therapeutic modalities. With additional consumer awareness, concern for transmission of hepatitis and demand for transfusion services, a particularly forceful incursion has taken place. Concerned persons both within and without the blood banking community have sought solutions and come to recognize that many of them are amenable to regionalization. Regionalization of blood banking will have three important components: assignment to one blood center responsibility for providing blood supply to hospitals in a geographic area, unification of donor recruitment programs and allocation of special functions (such as pheresis or HLA typing) to specific blood centers.

Busy physicians may have little concern about blood banking. This is understandable since much blood banking activity takes place at community blood centers far from a physician's daily

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activity and about which they have little knowledge. However, in this modern era of medical care, blood transfusion has become an integral part of the daily life of a physician and his patients. Much that a physician or surgeon does on a daily basis cannot be done without a dependable supply of blood. If the physician feels that blood banking is remote from his everyday activity, it is likely that those planning the changes necessary to accomplish regionalization will see the physician as peripheral to their concerns. Ongoing need for physician concern with blood banking, its future, and some possibly precipitous changes merit serious consideration.

## History

Most parties would agree that the well known Cunningham decision (1970)<sup>1</sup> marked at least the beginning of the accelerated phase in blood banking in Illinois, where it was followed by the blood labeling act (HB 4445) in August, 1972.<sup>2</sup> In 1970, the National Academy of Science and National Research Council, responding to concern for adequacy and cost of hemophilia therapy, published the first overall description of blood banking services and coined the term "blood service complex." With this description came several recommendations for unification, standardization, and centralization.<sup>3</sup>

Federal legislation in 1971 (sponsored in part by a senator from Illinois) led to a call for a national blood policy.<sup>4</sup> This was carried further on the upsurge of public interest in blood resources by the largely unfavorable comparison of our "blood service complex" to the British National Blood Service by Professor Richard Timuss of the London School of Economics.<sup>5</sup>

In March of 1972, blood was declared a national resource by the President of the United States. In September, 1972, Public Law 92-423 extended the authority of the National Heart and Lung Institute to use of blood, blood products, and management of blood resources, with responsibility to develop a national blood program. This program was to emphasize five areas of activity: a nationwide blood system; provision of safe blood; improved blood component therapy; education, both public and professional; and finally, transplantation biology.

At the same time, government regulatory authority for blood was shifted to the Food and Drug Administration. Blood was declared a drug (a product) and subject to the entire body of relevant federal regulations and planned Good Manufacturing Practices.

In 1973 the government enunciated the Na-

tional Blood Policy.<sup>6</sup> It set forth four goals: an adequate supply of blood, attainment of the highest standards of transfusion therapy, equal accessibility for all citizens and maximum efficiency and cost effectiveness in operation. This was followed by a call to the blood banking community (the private sector) to implement this policy. The American Blood Commission followed with developmental task forces to achieve the four National Blood Policy goals.

In Illinois, the Department of Public Health published regulations defining a voluntary blood donor and governing otherwise unaccredited blood banks and enunciated a state blood policy with three goals. These were: achievement of a totally voluntary blood donation system, unification of the pluralistic blood service system, and more equitable management of special blood users' needs. To implement this policy, a blood banking task force was set up which ultimately achieved the first goal. Over 99% of blood transfused in Illinois is now obtained from volunteer donors. Over the span of its existence, the task force grew to unmanageable size and was dissolved without addressing its latter two goals.

## Activity Accelerates

Two events in 1979 raised the pitch of public concern for quantitative and qualitative aspects of blood services in the State of Illinois. The first of these was a set of hearings held by the Human Resources Committee of the Illinois General Assembly to inquire into the activities of the blood service complex in the state of Illinois. The second was a resolution passed by the Illinois State Medical Society House of Delegates which called for regionalization of blood banking in the state of Illinois. This served as a mandate to the ISMS Laboratory Services Committee to develop and implement a plan for regionalization. These two events were direct results of recognition by persons outside the blood banking system of major inadequacies and inequities within the system. The first was stimulated by several newspaper articles documenting the influence of self interests in setting priorities, policies, and public attitudes within blood centers and resultant competition and antagonism between blood centers. The second was initiated by a physician, unable to obtain blood for his patient, seeking a solution through his professional society.

While it is impossible to predict the outcome of the House Human Resources Committee hearings they clarified serious inadequacies and inequities in the existing system. The final outcome is likely to be a legislative mixed blessing at best.

The result of the Illinois State Medical Society resolution was formation of a blood bank coordinating committee made up of medical directors of blood centers serving the state. The committee is to function as a catalyst in coordinated efforts to address and resolve issues raised in the House of Delegates resolution. It seeks to achieve those goals voluntarily in the private sector and obviate the need for legislative intervention.

Even spokesmen for the blood system agree that it needs some modification. Sporadic blood shortages, confusion in the public mind about blood supply adequacy, frequent "shopping" necessary for a hospital to assure its blood supply and cost variation from supplier to supplier, all speak eloquently for centralized control of the blood service complex.

While problems are generally more severe in the Chicago metropolitan area they are significant in most areas of the state. Of the many defects in the system three should be of concern to the practicing physician and require greater physician involvement as a remedy.

### Systemic Defects

Patient population stratification is the first of these problems. As a result of various blood assurance plans, variation in the nature of both the community in which hospitals are based, and services provided and resultant variation in patient populations, blood supply distribution is uneven, as is blood availability. This has the effect of stratifying the patient population according to probability of a readily available blood supply. At the highest level are those transfused in "total service" hospitals, that is, hospitals whose blood centers' contractual agreements provide all their

blood needs. At the middle level are those guaranteed through a blood assurance plan that in times of blood shortage blood will be found to meet their need. At the lowest level are those patients without a blood assurance plan, in a hospital without a total service agreement, whose blood supply is dependent on the blood bank director's ability to secure a supply. Unfortunately, the latter are usually in tertiary care hospitals with greater and more complex blood needs.

The second defect in the current system which is of interest to practicing physicians derives from two different views of the blood service complex. The first is a concept of the blood service complex based on the assumption that blood is a community resource; that the provision of blood is solely a community responsibility. This leads to visualization of the blood service complex as a cascade, as shown in Figure I. This initiates with donation of blood in response to community demand, proceeding through collection, processing and distribution, ultimately to be transfused into the patient. A subtle but important consequence of this cascade analogy is that blood flows in one direction, from the community to the patient. A point of paramount importance is that the physician enters the picture at a relatively late stage in the process. Another subtle effect is the implication that the patient is not an integral part of the community and is therefore detached from the process. This cascade view of the blood service complex is one generally held by those who operate community blood centers, from which the majority of blood in the State of Illinois (as well as the nation) is derived. It often serves as the rationale for viewing hospital blood replacement programs or physician recruitment of donors as counter-productive. Further, it makes the replacement fee an "unethical" donor incentive and relegates the physician to a minor role in the process. It was public pronouncement of this atti-

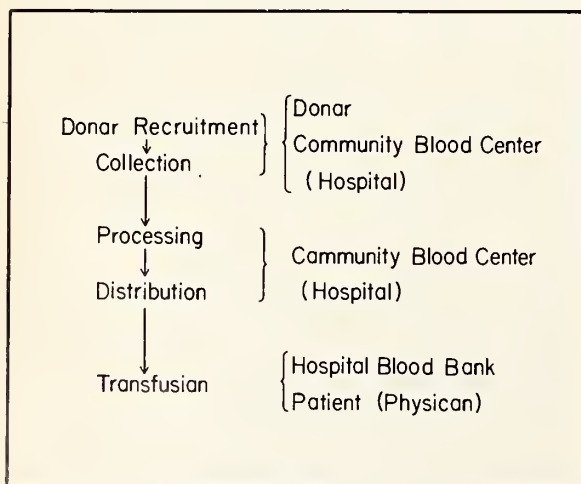


Figure I  
The "cascade" blood service system.

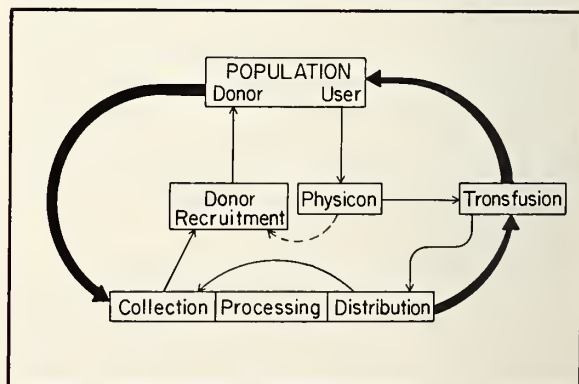


Figure II  
The closed circle blood service system.



tude which attracted media attention and led to newspaper articles which stimulated the House Human Resources Committee to act.

A more realistic view, in my opinion, is diagrammed in Figure II. This shows the blood service complex as a closed circle. At the top, there is the general population divided into two groups, donors and users. At the *center* are the physicians. Individual members of the community move back and forth from one compartment to the other in the course of their lifetime. A patient's need, translated by a physician into a demand for service from the blood bank, is really the driving force in the system. Blood flows out of the community into the blood center, where it is processed and stored and, in response to a physician's demand for service, moves to the hospital transfusion service and then is transfused to the patient.

If we examine this schema, with its epicycle of physician demand, we see a new and important relationship arise. Physicians have lived so long with the current system that they have forgotten that the genesis of blood banks derived from a need to shorten the delay in providing blood for transfusion and ultimately to be able to anticipate demand.

The central fact of this concept is patient need—translated by a physician into demand for transfusion of blood or, with ever-increasing frequency, a blood component. This demand is transmitted to the distribution function of the blood service system (community blood center or hospital blood bank). If this demand disturbs the collection/distribution equilibrium, it will, in turn, be transmitted to the collection function and thence to the donor recruitment function, which responds by drawing further upon the donor resources of the general population. It is only when supply and demand are at equilibrium that the focus shifts away from patient need/physician demand as the central issue.

If there is a shortage or need is unusual, the physician steps in and demand is communicated directly to the donor resource pool by the patient, his friends or relatives.

This occasional intervention is a frequent source of friction between physicians, hospital blood banks, and community blood centers because donor recruitment by the patient, the physician, or hospital blood banks for special needs often embarrasses the community blood center which has given assurance to the community that donation by a given number of donors would assure blood availability to all and that special donations are unnecessary.

This second scheme has two features which bear emphasis. One is that the patient and his physician initiate the process and are in a unique position to determine the true adequacy of blood service complex response. (It was a physician's exercise of this prerogative which led to the Illinois State Medical Society House of Delegates resolution.) The second is that patient and donor really have a more proximal relationship than is apparent in the cascade concept. The former creates a rationale for the physician to recapture his role in blood service complex evaluation and remodeling necessary to achieve truly adequate regionalization. The latter emphasizes that the patient or his surrogates are in a unique position to augment donor recruitment and blood supply. By recognizing the validity of the "replacement" philosophy, the physician is in an excellent position to increase public awareness of the need for an adequate blood supply.

This leads to the third defect of the current system. That is the absence of any external review system. No one outside the supply portion of the circle or the early part of the cascade participates in critical assessment. Providers are left to judge themselves. One has only to examine inspection and accreditation procedures to see that great pains are taken to assure that quality, potency, and sterility are carefully guarded, but no assessment is made of product availability or system responsiveness. This lack is to be expected since the physician-user is excluded from the evaluation process either deliberately or inadvertently.

## Conclusion

We have sought to remind the practicing physician of his true place at the center of hemotherapy activity and to recall him to that position.

Practicing physicians are now on the periphery of blood banking with little input. Blood banking is about to undergo another convolution. If physicians do not take advantage of the opportunity to re-insert themselves into a central role, they will find themselves outside the pale, totally without recourse: functionaries in a system beyond their control and unresponsive to their needs.

The Illinois State Medical Society Laboratory Services Committee is attempting to provide a means for physicians to voice their views on blood service to their patients, to suggest solutions and to help mold a system in the best interest of their patients.

The House Human Resources Committee is providing an additional strong stimulus and palpable measure of the urgency with which we must

devise and implement solutions to problems perceived by legislators—in concern for the common good both as surrogates for their constituency and as potential users themselves.

As user surrogates, physicians have a very large stake in the outcome of both legislative and blood bank coordinating committee activities. It is of paramount importance that they assume their role at the center of blood service system and make their voices heard. ◀

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# Illinois Housestaff News

## Why Can't We Get Them Early?

Membership in professional medical organizations is a topic of considerable concern both at the organizational and training-related levels of medicine. Despite nearly 1,000 physicians in the ISMS-RPS, the question as to why there is not still greater participation and retention after training constantly arises.

The decision to join organized medicine is usually made during medical school or residency training. Reasons to join are often very simple at the outset. Often the decision is based merely on the direct, tangible benefits the student/resident receives (journals, insurance, etc.) without much thought given the effects of membership on later careers. In actuality, no more than a few percent at best join AMA/ISMS/county societies to guide their destinies in medicine. We come upon the majority, who have little or no reaction to the events that influence our profession, with sparse comprehension and little interest in the complexities of health care. This isn't an unreasonable statement when one considers the college-medical school-residency program progression where the only goal presented is that of becoming a physician. The constant growth in regulation, encroachment, and public backlash are not often considered during this time. Setting

aside the group that is either apathetic or generally unaware as the primary basis for non-involvement, there remains a significant segment of new physicians who view organized medicine as an ogre-like overseer preserving the self-serving interests of the "fat cat" medical establishment. When seminars, free health services and health legislation are brought up as positive effects of our organization, they are often overlooked as "side jobs" or public relations. It is this last group of physicians who are constantly wary of our intent and believes we are giving medicine a "bad name."

The ISMS-RPS is concerned about the present and future situation of membership in organized medicine. There will always be that segment of physicians who refuse membership in a "self-aggrandizing" group. They still serve the positive benefit as "devil's advocates." More importantly, we must address our attention to the much larger group of uninformed or apathetic physicians who could benefit most from additional "medical education." It is our intent to instill at an early stage of the medical career an increased awareness of the profession's impact on the individual.

Brad L. Epstein, M.D.  
Secretary/Editor

*\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.*

# Pulse of the ISMS Auxiliary

## President's Acceptance Message

### Installation Luncheon—ISMS Auxiliary Annual Meeting

MRS. HARLAN FAILOR

APRIL 15, 1980



*It was in May of 1922 that 26 doctors' wives from eleven states met in the Statler Hotel in St. Louis to adopt the resolution that created the Woman's Auxiliary to the American Medical Association. The stated purpose of the new organization was "to extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement in health and education, to assist in entertainment at all medical conventions, to promote acquaintanceship among doctors' families so that closer fellowship may exist."*

*The Auxiliary image has changed over the past 58 years. We are no longer an organization for women only, and we no longer promote our causes through other groups. The Medical Auxiliary is a large volunteer health organization comprised of 80,000 members. In my President's Acceptance Message, I look at the Auxiliary today.*

For just a few minutes, I'd like to look, with you, at Auxiliary . . . which is as easy as picking up the mirror in front of you. For the Auxiliary is you . . . and I . . . and doctors' spouses all over the country.

"Unto whomsoever much is given, of him shall be much required."

As a physician's spouse, we inherit a special place in our community. You may argue that the doctor's position is not what it used to be and that doctors' wives no longer feel the pressure of social and volunteer leadership. But, if you will be honest, you have to admit that—like it or not—we have the means, we have the education, and we have a certain "built-in" respect which makes us a privileged group, and with this *privilege* (of being given much) comes *responsibility* (of him shall be much required).

Because of my religious upbringing, I suppose, I have always felt that the noblest professions were "healing" and "teaching." We, in a medical marriage, have the opportunity to do *both*. Our spouses, in their offices, are *healing* sickness, while we, in our communities, are *teaching*

wellness. Just how is this "wellness" being taught?

It's being taught in health projects and programs like "Shape Up For Life," in immunization campaigns, in CPR instruction. . . .

It's being taught in fund raising for AMA-ERF where our money buys research and guarantees medical students their education. . . .

It's being taught in legislative action which concerns itself with safety and physical examinations and drug abuse.

Apart from our husbands, no one knows the territory and the product as well as we do, for "wellness" and "sickness" are just two sides of the same coin.

Now if you use your mirror to look over your shoulder, you'll see another aspect of Auxiliary: the doctor and the Medical Society.

In this era of Women's Lib, some wives object to belonging to an organization whose "membership privileges" depend upon their husbands. These women prefer to "do their own thing"—"be their own person." I see the Auxiliary as a



chance to strengthen and support the most important person in my life. I like the idea of health care being a family affair.

Back in grandfather's day, the office at home allowed grandmother to tend the minor illnesses while grandfather cared for the major ones. When modern technology took the doctor out of his home to a central location where he could share expensive equipment and his "specialty" with colleagues, the doctor's spouse lost her close tie to medicine. Maybe this is why the Auxiliary was founded: if a wife could not share her husband's practice, she could at least share his major concerns.

And on the subject of shared concerns, I have observed that the strongest Auxiliaries are the ones that have a good working relationship with their corresponding Societies. The Auxilians attend Society meetings; the two groups exchange minutes and have joint planning sessions. It's a well-recognized fact that we can do more *together*.

"The Auxiliary Image—a Reflection of You." At the national level we are 80,000 strong—a wide-angle lens couldn't provide a photograph; but how do we look at the local level—where it

really counts? Are we a picture of health?

Your State Auxiliary is dedicated to helping you build the best possible image within your county. The two Leadership Seminars and the Fall Conference in Decatur were planned with that goal in mind.

But sometimes we look for things "without" when we should be looking "within." *Every* member and every potential member has something to give the Auxiliary. And we—the Auxiliary's leaders—must find and unwrap those gifts.

If a member is a good speaker, we should put her before community groups. . . .

If a member loves to socialize, we should place her on the membership or hospitality committee. . . .

If a member has an interesting vocation, we should call upon her for a program.

We should have as many Auxiliaries in Illinois as we have Societies—what a community loss that we do not!

We have been given much—as doctors and doctors' spouses—and someday we shall have to account for our time and our talents. Why not put yours to use for Auxiliary in the coming year? ◀

## The CO<sub>2</sub> Laser In Gynecological Surgery

*A two-day, tutorial and hands-on workshop on the application of the CO<sub>2</sub> Laser to gynecological surgery. This workshop is approved for 12 credit hours in Category I of the Physician's Recognition Award of the AMA, and has been approved for 12 cognates Formal Learning by The American College of Obstetricians & Gynecologists.*

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## Physicians Required To Report Suspected Child Abuse

Illinois' Abused and Neglected Child Reporting Act (PA 81-1077) came into effect as of July 1. Under the law physicians are required to report suspected child abuse or neglect to the Illinois Department of Children and Family Services. DCFS has established a toll free 24-hour hotline for this purpose: 800-252-2873 (as a memory aid, readers may note that the number spells 800-25-ABUSE). In addition, a written confirmation must be forwarded to the local DCFS field office within 48 hours.

The DCFS brochure states: "Oral and written reports should include the names and addresses of the child and his parents or other persons having his custody; the child's age; his condition, including any evidence of prior injuries or disabilities; and name of the suspected child abuser and his or her relationship to the child; and any other information you believe would be helpful in establishing the cause or proof of abuse and identity of the abuser. By law, information may not be withheld on the grounds of preserving the confidentiality of your relationship with a patient or client."

DCFS further advises that physicians are

among those persons who "may take or retain temporary protective custody of a child without the parents' consent if they believe the child is in immediate danger. The Department must be notified immediately in such cases so it may initiate court proceedings for continued custody of the child." In such instances, if the physician acts in his capacity as a member of hospital or similar institutional staff, he must notify responsible personnel.

Under the law, mandated reporters must report any deaths which they suspect resulted from abuse or neglect to the medical examiner or coroner, who must investigate and report to all concerned parties within 72 hours.

DCFS has further advised that another law, PA 81-784, empowers the Illinois Department of Registration and Education to suspend or revoke the license of dentists, nurses, physicians, podiatrists and psychologists who willfully fail to report suspected child abuse or neglect.

Further information about the Act may be obtained by writing the DCFS Office of Community Relations, One North Old State Capitol Plaza, Springfield IL 62706; 217/785-2670.

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# Illinois Society, American Association of Medical Assistants

## Can Voluntary Effort Really Work in a Clinic or Office Environment?

BY MARYGRACE SANDERSON  
COOK COUNTY SOUTH CHAPTER

During her inaugural address to the Illinois Society of the American Association of Medical Assistants, President Elaine Kaiser, CMA-A, offered a direct challenge to the physicians and medical assistants present at the 24th Annual Meeting, recently held in the Arlington Heights Hilton Hotel. She called upon them "to come together to work effectively to solve our problems and to pull together, to understand and resolve them." Mrs. Kaiser stated, "It would be difficult if not impossible to pick up a newspaper or a magazine without reading about the high cost of health care. Physicians and hospitals are being blamed for skyrocketing health care cost, and the poor consumer (he is not called a patient anymore) is being told he is being denied his right to health care."

What can medical assistants do to lower health cost? What is our responsibility? Voluntary Effort has been offered as a possible solution to lowering the increase in health care cost. Voluntary Effort is a program initiated in late 1977 by three major national groups: the American Medical Association, American Hospital Association and the Federation of American Hospitals, along with health insurers, health industry manufacturers, representatives of government, business and consumer groups in a joint action to contain health care cost. They were concerned and hoped that a combined effort could make a significant contribution to the lowering of health care cost.

Can this program be implemented in the doctor's office? Yes. "I think we can be included in this effort," continued Mrs. Kaiser. "I think we can assess our office and find many areas that can be improved, cut back, or eliminated. It will re-

quire more understanding on the part of the medical assistant in working with patient complaints. Patients read the papers and they want to know why the office charge is so high and why their diagnostic tests are so expensive, and why Medicare hasn't reimbursed them like they promised. It requires more expertise on your part to complete claim forms to obtain the maximum benefits as allowed by the policy."

"You must find new and innovative ways to save on medical and office supplies, and become a more prudent buyer. It is up to medical assistants to recognize their positive effect on health care and what they can do to assist in lowering the rate of health care cost. We cannot remain in our protected environment in a small office or clinic and say that this doesn't affect us or our patients. We cannot say our efforts would be insignificant. Our efforts would be recognized by our physicians and certainly by our patients. Our efforts collectively would eventually be recognized by those who monitor health care expenses. Our physician employers know that they have a significant part in controlling cost and need our help. It is a marvelous thought with tremendous potential. Voluntary effort means cooperation, involvement, and commitment. It has to begin with the membership of the Illinois Society of Medical Assistants, AAMA. Your voluntary effort will make a significant change in your office and in your life."

For more information regarding AAMA contact Elaine Kaiser, CMA-A, president, 5700 Grange St., Oak Forest, IL 60452 or Marygrace Sanderson, chairman, Public Relations Committee, 501 Heathermead Road, Matteson, IL 60443. ◀

# Student Business Session in Action

## Smoke-Free Air and Patients' Rights

A recent article in the *New England Journal of Medicine* (March 27) re-focused attention on the issue of involuntary (passive) smoking. It showed that non-smokers chronically exposed to tobacco smoke suffer small-airways dysfunction.

Previous studies have provided evidence for deleterious effects of involuntary smoking on specific population subgroups. Children of parents who smoke have an increased incidence of bronchitis and pneumonia. Carbon monoxide levels often reached in cigarette smoke-filled environments reduce the exercise duration required to induce angina pectoris, intermittent claudication, and dyspnea in patients with coronary artery disease, iliofemoral occlusive artery disease, and chronic obstructive pulmonary disease, respectively. Allergic and irritative effects of tobacco smoke are common. One survey reported the following frequency of reactions in 250 nonallergic patients: eye irritation (69%), headache (32%), nasal symptoms (29%), and cough (25%). Tobacco smoke may be an especially frequent eye irritant to wearers of contact lens and may exacerbate symptoms of asthma.

State laws protect the rights of non-smokers to varying degrees in over 30 states by regulating smoking in public places. Sadly, Illinois isn't one of these. Although physicians are limited individually in their ability to affect legislation, they can exert considerable influence in their own domain—namely, their offices and the hospitals where they work. In fact, there is probably no better place to begin.

First we should recognize that the hospital, more than any other place, should offer a safe, health-promoting environment. And, as alluded to above, the already less-than-fit patient is often the most susceptible to the ill-effects of involuntary smoking. Finally, we should not ignore the psychological reaction to cigarette smoke. A national survey in 1975 revealed that 79% of non-smokers and 35% of smokers find it "annoying to be near a person who is smoking cigarettes." The effect would be greater on the patient, who probably is less likely than the healthy non-smoker to have the strength of mind or body to ask others not to smoke, to temporarily seek a more hospitable locale, or to change rooms (assuming that such possibilities are available). As the relationship between stress and health receives increasing attention, removing unnecessary stress to hospital patients caused by involuntary smoking would be a desirable achievement.

What is the extent of the problem? A recent survey of 360 randomly selected hospitals<sup>1</sup> found smoking regulations to be generally quite lax. For instance, only 50% of the hospitals restricted smoking in the pediatric area, and only 6% prohibited smoking in waiting rooms. Influence from medical personnel in these policy decisions was minimal. Rather, the smoking regulations correlated significantly with the smoking behavior of the hospital administrator.

How, then, can we proceed to try to improve this situation? First, patients should be guaranteed the right to choose an officially designated "no smoking" room. The survey just mentioned



found only 46% of the hospitals offering such a choice. An even better approach is the one developed by the Louis A. Weiss Memorial Hospital in Chicago.<sup>2</sup> It set aside an entire patient floor as a no-smoking area. Large, specially designed signs were placed at the nurses' station, in the corridors of the unit, and in the stairwells near the doors leading to the floor. A special visitor's pass was prepared for the no-smoking unit, and visitors are also given a one-page written explanation of the purpose and function of the floor to reinforce the need for their cooperation. Patients who request assignment to this unit are made aware that their friends and family may not smoke when they come to visit. Physicians and employees are likewise informed of the restrictions.

The program was enthusiastically accepted by patients, the public, and hospital employees. In fact, the no-smoking unit has consistently had the highest occupancy rate of any medical-surgical unit in the hospital. After the initial 6-month pilot program, a recommendation was made to expand the no-smoking concept to a second patient care unit.

Finally, an effort should be made to restrict smoking in other higher-risk patient care areas such as intensive and coronary care units, and pediatric, labor and delivery areas. Smoking should be restricted to only designated areas in cafeterias, waiting rooms, lobbies, etc.; or prohibited when such segregation is not feasible.

What does organized medicine have to say about all of this? Policy statements of the ISMS and AMA support the concept of patients' rights to breath smoke-free air. ISMS "is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free." The AMA urges physicians "to become exemplars for their patients and their communities by stopping smoking themselves, by placing 'no smoking' signs in their offices and waiting rooms and by discouraging smoking in the hospitals where they work."

However, it cannot be overemphasized that significant progress will not be made unless individual physicians, medical students, and other hospital personnel provide persistent input into the appropriate hospital channels through which such policy decisions are made. ◀

Ronald M. Davis  
Delegate, ISMS-SBS

#### References

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2. Zimmerman, M.W.: "No Smoking, Please!" *Hospitals* 52:183, 1978.

## Clinics for Crippled Children Listed for August

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 24 general clinics, 9 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Division Cardiac—U. of I. at the Medical Center
- 5 Maryville—Oliver C. Anderson Hospital
- 5 Park Ridge Cardiac (a.m.) Lutheran General Hospital
- 5 Park Ridge General (p.m.) Lutheran General Hospital
- 5 Wheaton General—Marianjoy Rehab. Hospital
- 6 Hinsdale—Hinsdale Sanitarium
- 6 Rockford—St. Anthony's Hospital
- 7 Lake County Cardiac—Victory Memorial Hospital
- 11 Peoria Cardiac—St. Francis Hospital
- 11 Chicago Heights Cardiac—St. James Hosp.
- 12 East St. Louis—Community Hospital
- 12 Peoria General—St. Francis Hospital
- 13 Champaign-Urbana—McKinley Hospital
- 13 Joliet—St. Joseph's Hospital
- 13 Aurora MM—Mercy Center for Health Care Services
- 14 Aurora Cardiac—Mercy Center for Health Care Services
- 14 Kankakee General—St. Mary's Hospital
- 14 Rockford—Rockford Memorial
- 14 Springfield General—St. John's Hospital
- 14 Anna—Union County Hospital
- 15 Kankakee Cardiac—St. Mary's Hospital
- 19 Maywood—Loyola Medical Center
- 19 Belleville—St. Elizabeth's Hospital
- 19 Rock Island Area General—Moline Public Hospital
- 20 Springfield Ped-Neuro—St. John's Hosp.
- 20 Aurora General—Mercy Center for Health Care Services
- 21 Bloomington—Mennonite Hospital
- 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 22 Evanston—St. Francis Hospital
- 25 Chicago Heights Cardiac—St. James Hosp.
- 25 Peoria Cardiac—St. Francis Hospital
- 27 Elgin General—Sherman Hospital
- 27 Chicago Heights General—St. James Hosp.
- 28 Litchfield—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ATKINSON:** A modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond-Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles to Peoria (UI). All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235 (309-936-7566). (11)

**BLOOMINGTON:** Physician to work in anesthesia mornings, general practice afternoons. Space available in clinic with podiatric group of 4 doctors. Attached ambulatory surgical facility. Central Illinois community, area population over 100,000. 135 miles from Chicago, near Universities and Colleges. For further information contact: Dr. H. R. Hadden, 2708 Mc Graw Dr., Bloomington 61701 (309-633-2306). (8)

**CARBONDALE:** Primary care physician (M.D. or D.O.) for Health Service at prominent university which includes an aggressive wellness program and a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. Ability to fluently converse in English and IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, 62901. (11)

**CHICAGO AREA SUBURBS:** Western Cook, DuPage Counties, including Oak Brook, Downers Grove, Wheaton, Lombard, LaGrange, Palos Hills. Opening in new and established multi-specialty medical groups. Complete office facilities with nearby hospital affiliations. Various practice and financial arrangement available. General Practice, Internal Medicine, Family Practice, Obstetrics & Gynecology, Otolaryngology, and Orthopedic Surgery. CONTACT: Jim Gott, Administrator, Suite 205, 6800 S. Main Street, Downers Grove, 60515, 312-852-9400. (12).

**DANVILLE:** Multispecialty Group in new building seeking E.N.T., F.P./G.P., Cardiologist, Neurologist, and Ophthalmologist. Salary with early shareholding and income based on productivity. Excellent corporate benefits. Central Illinois/Indiana border location. Contact: A. Reese Matteson, M.D., Danville Poly-clinic, Ltd., 101-103 W. North, Danville 61832. (217-446-6410). (9)

**EFFINGHAM:** Anesthesiologist needed to assume the position of Director of Anesthesia Services. Excellent hospital facilities with a spacious new surgery department and a service area of 75,000 population. Opportunity available combining the convenience of urban living with a progressive rural community designated a growth area. Effingham is located in south central Illinois at the intersection of two major interstate highways, I-70 & I-57 and offers excellent school systems and recreational activities. Respond with CV to: James M. Brophy, St. Anthony's Memorial Hospital, 503 N. Maple Street, Effingham, 62401 (217) 347-1324. (9)

**EL PASO:** Family practitioner for rewarding primary care and family physician. Fully equipped office in excellent location. Primarily farming community in North Central Illinois. Fifteen miles from hospitals in Normal-Bloomington with cultural advantages of two universities—Illinois Wesleyan, and Illinois State University. Ten miles from Eureka Hospital and 35 miles to Peoria with U of Ill Medical School and Bradley University. Financing available. A warm, personal community that would welcome a needed physician. CONTACT: Kearney Clinic, 3 Grant Street, El Paso 61738 (309-527-5752). (7)

**EVANSTON:** *Medical Director*—Internist or general practice physician to supervise and participate full-time in care for residents in 37-acre retirement village. M.D. with Board Certification in Internal Medicine or Family Practice. Geriatric experience preferred. Academic, clinical and research potential. Campus includes independent living, sheltered care, intermediate and skilled-care nursing care components. Send curriculum vitae to: Frank K. Hoover, President, THE PRESBYTERIAN HOME, 3200 Grant Street, Evanston, 60201. (11)

**FAIRBURY:** Primary Care and Family Practice Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739 (815-692-2346). (12)

**FREEPORT:** Urologist, Ob-Gyn, and General Surgeon, Board Certified or Eligible, to join multi-specialty group in community of 35,000 in Northern Illinois. Salary negotiable first year, then partnership. Excellent retirement and fringe benefits. Send curriculum vitae and references to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 3103 West Stephenson Road, Freeport, Illinois 61032. (815-235-6131). (7)

**FRANKFORT:** Pediatrician wanted for 10 man multi-specialty group, thirty miles southwest of Chicago. Profit sharing, new building and excellent practice opportunity. Contact: Howard Osmus, Administrator, Hedges Clinic, Frankfort 60423 (815-469-2123). (8)

**GLEN ELLYN:** Needed immediately—Qualified internist to join large multispecialty practice in Western Chicago Suburbs. Unique opportunity with recent clinic expansion. First year guaranteed salary with incentive and excellent fringe benefit package. Contact: Dave S. Bauer, Executive Director, Glen Ellyn Clinic, S. C., 454 Pennsylvania Ave., Glen Ellyn, 60137 (312) 469-9200.

**HINSDALE:** Western suburbs of Chicago. Wholistic Health



Center of Hinsdale. Facilities already established in the Union Church. Prefer certification or experience in Family Practice. Must be committed to working with team. Salary and contract negotiable. Contact Dr. John Payne, 137 S. Garfield, Hinsdale, IL, 60521. (7)

**JOLIET:** General Practitioner—opening available in medical clinic consisting of four GP's and two Surgeons. Salary for one to two years and then full partnership. Located in city of 100,000, close proximity to Chicago. Excellent schools, good cultural environment. Salary is negotiable. Alternate night calls with GP's in group. Write: Family Medical Group, S.C., 330 Madison St., Joliet 60435 or call: 815-735-3440. (11)

**LAKE COUNTY:** The Lake County Health Department is seeking a high energy Psychiatrist for our outpatient clinic. This individual will provide consultation to staff, psychiatric evaluation and medical monitoring of clients. Contact Dr. David Grossman, 312-689-6725 or Jeff Epstein, Ph.D., 312-689-6729. (11)

**MT. VERNON:** Board Certified or Eligible OB-GYN to join 36 year old established same in rapidly growing town of 20,000 with good schools, nice people, lots of recreational opportunities and easy access to St. Louis. Modern 200 bed JCAH hospital; new office in the works. Good initial salary and benefits and early partnership. CONTACT: Tom Weinberg, M.D., PO BOX 1604, Mt. Vernon 62864 (618-244-2235). (8)

**OBLONG:** Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed

JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

**PALMYRA:** Population 800, three more villages in our school District. No doctor at present. New doctor's office equipped free of charge, utilities furnished. Hospital less than an hour drive, ambulance service, recreational facilities, and nearby airport. CONTACT: Oral Cooper, Village of Palmyra, Palmyra, 62674 (217-436-2521). (8)

**PEKIN:** Family practice physician needed. City Population 40,000, county population 130,000. We are looking for a high-caliber professional to join the staff of our modern 206 bed hospital. Our hospital features a full range of modern, well maintained support services and excellent nursing care. Our community has an outstanding school system, the second largest park system in the State of Illinois (over 2,000 acres), two country clubs, four golf courses and beautiful residential areas. Our recruiting package includes an income guarantee competitive with anyone in the country, office expense allowance, moving expenses and assistance in securing home and business loans through local banks. Contact: Robert Tucker, M.D. or Norman F. Webb, Administrator, Pekin Memorial Hospital, Court & 14th Streets, Pekin 61554 (309) 347-1151. (11)

**PINCKNEYVILLE:** General Surgeon to replace present Board Certified Surgeon, leaving for fellowship. Board Eligible or Board Certified to join three family practitioners in four man group. Modern Hospital and Medical Building. For details call 618-357-2131. Pinckneyville Medical Group, 206 N. Main, Pinckneyville 62274. (11)

## **CHIEF RADIOLOGIST NEEDED BY OCTOBER, 1980**

**St. James Hospital**

**Chicago Heights, Illinois 60411**

**A 440 bed hospital and  
Trauma Center**

**Department of Radiology**

**Recently remodeled  
and re-equipped**

**CT Scan and Ultra Sound**

*Please send inquiry to  
S.A. Dekowski, M.D.,  
President, Medical Staff*

## ***On The Cover . . . .***

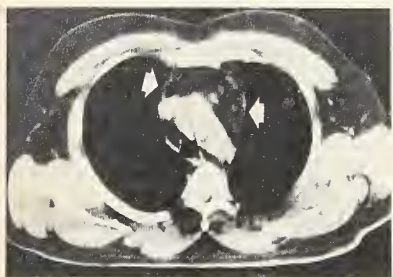
Many thoughts come to mind when viewing this picture. We first are reminded of our nation's independence, also reflected by the colors present, representing the flag. Then, there is the impression of freedom—free floating by means of a balloon. This also indicates an escape by being adrift, not tied down.

We can create many illusions or allegories pictorially.

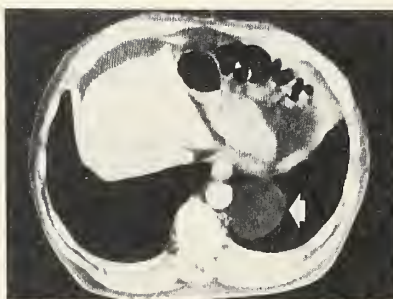
Hopefully, the readers will see in this a symbol of our country and the ability to live free, guided by our individual tenets.

# Viewbox

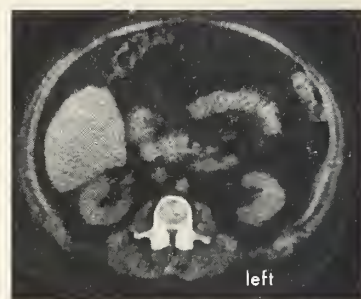
(Continued from page 7)



**Figure 1A:**  
Abundant fat at the level of the aortic arch. (arrows) Note mediastinal tissue is same density as subcutaneous fat.



**Figure 2A:**  
Lipoma (arrow) adjacent to spine.



**Figure 3A:**  
Left kidney displaced by fat.

Patient 1 is very obese and the mediastinum is widened by fat deposition. Similar findings may occur following steroid therapy or in Cushing's disease.

Patient 2 has a left paraspinal lipoma. Omental fat in a foramen of Bochdalek hernia could give a similar appearance.

Patient 3 is obese and retroperitoneal fat displaces the left kidney. The spine, aorta, kidney, and retroperitoneum are normal.

The appearance of the radiographs in these patients could be due to primary malignancies, lymph node enlargement due to benign or metastatic disease, or aortic aneurysm and its complications. In each case, C.T. not only identifies fat as causing the previously observed abnormalities, but rules out any additional pathology. One of the primary advantages of C.T. compared to conventional radiography is the ability to identify mass lesions as solid, cystic, vascular, or fatty.<sup>1,2</sup> Fat is usually readily identified by comparison to normal body fat or tissue density can be more exactly measured using C.T. density numbers calculated by the machine.

In the era prior to the availability of computed tomography, patients with mediastinal and retroperitoneal abnormalities such as these posed a diagnostic dilemma. Even following several diagnostic procedures, some invasive, surgery was often required to make a diagnosis. Computed tomography can give a definitive diagnosis of fatty lesions and identify vascular structures simulating neoplasm (such as a buckled right brachiocephalic artery). In these cases, the patient is

spared morbidity, anxiety associated with multiple procedures, and expense.

## References

1. Love, L., Reynes, C., Churchill, R., Moncada, R.: "C.T. Scanning in Renal Disease," *NA Clin. Radiol.* 17:77, 1979.
2. Pugatch, R.D., Facing, L.J., Robbins, A.H., Spira, R.: "C.T. Diagnosis of Benign Mediastinal Abnormalities," *Amer. J. Roentgen.* 134:685, 1980.

## Cook County Graduate School of Medicine CONTINUING EDUCATION COURSES

**A. M. A. Accredited**  
**September 1980**

**Advanced Peripheral Vascular Surgery**  
September 15-19, 1980

**Sexual Medicine**  
September 22-26, 1980

**Specialty Review in Dermatology**  
September 22-26, 1980

**Fiberoptic Colonoscopy**  
September 24-26, 1980

**Specialty Review in Obstetrics & Gynecology**  
September 29-October 3, 1980

*For further course offerings, information and registration, please write or call.*

**Registrar**

**Cook County Graduate School of Medicine**  
707 South Wood Street, Chicago, Illinois 60612  
(312) 733-2800



# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

Dear Colleague

Periodically, I hear people complain that they don't believe in voting because ONE VOTE DOESN'T MATTER ANYWAY.

Needless to say, I disagree and I recently came across some examples of the kind of difference one vote can make.

One vote made Oliver Cromwell Lord Protector of the Commonwealth and gave him control of England. (1645)

One vote caused Charles I to be executed. (1649)

One vote decided that Americans speak English rather than German. (1776)

One vote kept Aaron Burr, later charged with treason, from becoming President. (1800)

One voted elected Marcus Morton governor of Massachusetts. (1839)

One vote made Texas part of the United States. (1845)

One vote saved President Andrew Johnson from impeachment. (1868)

One vote changed France from a monarchy to a republic. (1875)

One vote admitted California, Idaho, Washington and Oregon to the Union. (1850, 1890, 1889, 1859)

One vote elected Rutherford B. Hayes to the presidency, and the man in the electoral college who cast that vote was an Indiana congressman elected by one vote. (1876)

One vote made Adolph Hitler head of the Nazi Party. (1923)

One vote saved the selective service system only 12 weeks before Pearl Harbor. (1941)

As you can see, one vote does count. And if you consider the ten or one hundred or one thousand votes that never are cast each election because the potential voter forgot to register, the significance of each of those "one votes" becomes greater.

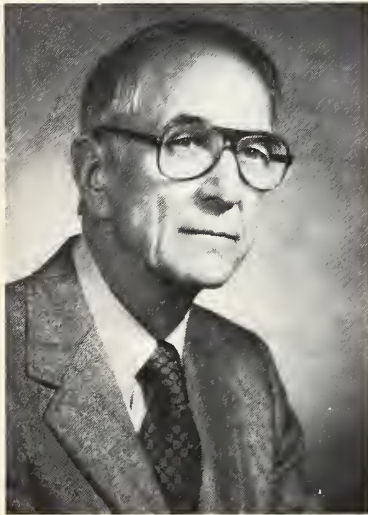
Don't let your one vote be uncounted. Make sure you register to vote before October 1st. In our democracy the people select their government, but you won't have a chance to participate if you are not registered. Mark your calendar now; register; become informed; then vote on November 4th.



Paul Mahon, M.D., Chairman

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# President's Page



## *An Idea For the 80's* **Graduate Program in Health Advocacy**

The nation's first graduate program in health advocacy begins this fall at Sarah Lawrence College, Bronxville, N.Y. The master's degree course is designed to train "patient representatives" who will develop ombudsmen programs for hospitals, nursing homes, prisons, HMOs and government health agencies.

In 1973, the American Hospital Association developed a "Patient's Bill of Rights." Hospitals traditionally have relied upon volunteers to carry out advocacy functions. Now the Sarah Lawrence program is evolving, based upon the principle that nothing less than professionally-trained ombudsmen can effectively cope with health care's bureaucratic jungle of medical-legal issues. The curriculum contains courses in medicine, law, economics and the structure and history of the health care system. Each semester also includes a course on health advocacy.

It is comforting to think that a specially-trained "professional" will answer my patients' questions about cold food, delays in tests and other misadventures. Less appealing is the thought that, eventually, I will deal with a "third party" advocate who questions the appropriateness of a test or the need for medication.

A final scenario: You gave the wrong medicine (suit) . . . you made the wrong diagnosis (suit) . . . you overcharged (suit). This is harsh, but fair. Advocates seldom are needed for the "good times." ◀

*Herschel Browns, M.D.*

◀  
Herschel Browns, M.D., President



# Doctor's News

**RESOLUTION DEADLINE ANNOUNCED**—The ISMS House of Delegates Interim Session will convene October 25-26 at the Continental Regency Hotel, Peoria. Resolutions proposed for consideration at the Interim Session must be received in the ISMS offices no later than September 27, 1980. Those received at a later date will be considered late resolutions and require special consideration for inclusion at the Interim Session. Resolutions received in the ISMS offices by August 23, 1980, will be published, by title and author only, in the Delegates' Handbook. The Delegates' Handbook will be included in the October, 1980, issue of the *IMJ*.

**EDUCATION UPDATE**—A number of educational programs are planned for this fall. **September 10, 1980**, Illinois will join the SIU School of Medicine in co-sponsorship of the second annual Physicians Practice Opportunity Job Fair in Springfield. (ISMS will also co-sponsor the annual Doctor's Job Fair in conjunction with the Illinois Association of Osteopathic Physicians and Surgeons, scheduled for a later date.) On **October 16-17, 1980**, ISMS will join the American Society of Law and Medicine in a medical-legal seminar considering legal and ethical aspects of care for the terminally and critically ill patient. On **October 23, 1980**, ISMS plans a symposium on new health practitioners. This program will be held in Peoria, two days prior to the interim session of the ISMS House of Delegates. Further information on these symposia will be forthcoming.

**NEW DIRECTIONS FOR MEDICAL CARE—A CHALLENGE OF THE 80's** is the title of an AMA program scheduled for August 15-16 at the Radisson Downtown Hotel in Minneapolis, Minnesota. The program will focus on medical care planning, and the roles of medical staff leadership and private physicians. Cost to AMA members is \$225; non-member \$325. Hour-for-hour Category 1 CME credit will be awarded participants. Further information may be obtained by writing the Department of Hospitals and Health Facilities, American Medical Association, 535 N. Dearborn St., Chicago, IL 60610; (312)751-6653.

**ICCME ANNOUNCES NEW HANDBOOK**—*Physicians Improve Performance Through Continuing Education* reproduces eight studies published during the last decade which report changes in clinical performance as a result of physician learning. It includes analyses of negative opinions on CME and a summary of educational characteristics shared by the eight successful programs. The papers may serve as models for both CME program design and evaluation. The booklet may be obtained, at \$7.00/copy postpaid (50% discount to ISMS members) with prepayment to the Illinois Council on Continuing Medical Education, 55 E. Monroe, Suite 3510, Chicago IL 60603.

**POTAWATOMI FESTIVAL, INC.**, a non-profit organization which seeks to recognize contributions of citizens from the Attica, Indiana, region, has formed a fund to assure restoration of the John Evans, M.D., home in that city. Dr. Evans, for whom the city of Evanston was named, served as president of the Northwestern University Board of Trustees for 44 years, until three years before his death in 1897. Dr. Evans has been credited with many civic activities, including work toward establishment of Mercy Hospital and Medical Center and the first national quarantine law. He also was governor of Colorado, a founder of several railroads and a charter member of the Chicago Medical Society. Contributions to the Fund may be sent to P.O. Box 408, Attica IN 47918.

**PHYSICIANS IN THE NEWS**—Newly elected officers of the Jackson Park Hospital medical staff, Chicago, are **Jack Saley, M.D.**, Chicago, president; **S. Rafii, M.D.**, secretary; **Harry H. Farber, M.D.**, Olympia Fields, vice president and **Toussaint G. Toole, M.D.**, Chicago, treasurer.

A Loyola University Medical Center/Hines Veterans Administration branch of the Chicago Medical Society was recently formed, and elected officers. They are **John R. Tobin, Jr., M.D.**, Hines, president; **Walter S. Wood, M.D.**, Hinsdale, president-elect; **William Lees, M.D.**, Lincolnwood, secretary/treasurer and **Roland Cross, M.D.**, Oak Park, councilor. The new branch membership is composed of physician staff at Loyola's McGaw and Hines VA hospitals.

Newly elected officers of the Chicago Neurological Society are **Sandra Olson, M.D.**, Chicago, president; **Ronald P. Pawl, M.D.**, Lake Forest, vice president and **Ivan Lipman, M.D.**, Chicago, secretary/treasurer.

Illinois physicians recently made fellows of the American College of Physicians are **Robert W. Kirby, M.D.**, Champaign; **Athanasius Anagnostou, M.D.**, Charles S. Davis, M.D., Maceo R. Ellison, M.D., Edward A. Lichter, M.D., John E. Martin, M.D. and Sirus Naraqi, M.D., Chicago; **Petham P. Muthuswamy, M.D.**, Darien; **Vinod K. Bansal, M.D.** and **Mauro M. Paes, M.D.**, Downers Grove; **Benum W. Fox, M.D.**, Harry J. Miller, M.D., and **James C. Sheinin, M.D.**, Evanston; **David L. Faulk, M.D.**, Glen Ellyn; **Howard Schachter, M.D.**, Highland Park; **Nicholas J. Gross, M.D.**, Hines; **Bernard A. Nemchausky, M.D.**, Hinsdale; **Howard C. Fishman, M.D.**, Northbrook; **Vasant C. Gandhi, M.D.**, Oak Brook; **Parvez H. Shirazi, M.D.**, Park Ridge; **Loyd J. Wollstadt, M.D.**, Rockford; **Jay H. Kleiman, M.D.** and **Richard C. Stalzer, M.D.**, Wilmette; **Gary J. Vicik, M.D.**, Belleville and **Ronald L. Ruecker, M.D.**, Decatur.

New medical staff officers for Martha Washington Hospital in Chicago are **William O. Bates, III, M.D.**, Wilmette, president, **P. Roy, M.D.**, vice president and **Edward Sutoris, M.D.**, secretary/treasurer.

Lutheran General Hospital medical staff, Park Ridge, also recently named new medical staff officers. They are: **George Nelson, M.D.**, president; **Lawrence Levine, M.D.**, Niles, president-elect, **Richard Caldwell, M.D.**, Chicago, vice president, **Irwin Goldfarb, M.D.**, Wilmette, treasurer and **Don Larson, M.D.**, Chicago, secretary.

**Alex Goldstein, M.D.**, Harrisburg, has been named to join the Illinois Health Facilities Planning Board. A former ISMS delegate from Saline-Pope-Hardin, Dr. Goldstein has also served as president of the local Health Systems Agency.

**THE NATIONAL EMERGENCY NETWORK** is a new, worldwide patient identification system and emergency service developed by emergency physicians, nurses and rescue personnel, now available to patients throughout the U.S. The Network, which may be joined on an individual or family basis at \$15 per individual or \$30 per family for a three-year membership, provides annually updated medical information on a special card and toll-free access to an international data bank for hospital emergency personnel. Additional benefits include emergency assistance by ambulance dispatch for members in trouble and emergency information to members regarding nearest burn or poison control centers. Membership cards carry medical information, as do identifying stickers provided for cars and wallets. Further information may be obtained by contacting their regional office, 1130 N. Western Ave., Lake Forrest, IL 60045; (312) 234-0923.

**CORRECTION**—The May *IMJ* (157:5) on page 278, carried a brief article indicating statutory requirements regarding the necessity for physicians to register with their county clerk. This was verified with the Illinois Department of Registration and Education and is as the law appeared in the 1979 statutes. A little-noticed housekeeping bill in the General Assembly, which became PA 81-934, signed in late 1979, has removed the requirement that physicians include on the pre-marital examination form an identification that the physician has filed his credentials with the county clerk.



## SITUATIONS WANTED

**OB-GYN—BOARD ELIGIBLE**—seeks solo practice or association with either ob-gyn, or family practice physician. Write to Box #962 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**BOARD CERTIFIED INTERNIST**, young, seeks solo or group practice. Flex, small community considered. Contact Box #968 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**BOARD ELIGIBLE PSYCHIATRIST**, young, seeks solo, group or hospital based practice. Flex, small community considered. Contact Box #969 c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**DERMATOLOGIST**, thirty-three years old, training recently completed, with flexible schedule desires part time (20-30 hours/week) association with clinic, health maintenance organization, or practicing dermatologist in Chicago metropolitan area. James M. O'Dowd, M.D., 307 Buckthorn Lane, Hillside, Ill. 60162.

## FOR SALE, LEASE OR RENT

**PRIME INVESTMENT**, prime location, fronting beautiful, lush green scenic golf course. 10, 20, 30, 40 acres of gently rolling land, \$5,000 per acre and DOWN if large parcel purchased. Worthy of your investigation. Kindly call IREC, Inc. Melanie Everett, 649-6662.

**LARGE MEDICAL CENTER**: corner masonry building, 18 years old with 13 medical and dental practitioners. Gross income \$31,000. Doctor leaving for California and is anxious to sell. Please call Melanie Everett, IREC, Inc. 649-6662.

**FOR RENT—SUBURBAN—DELUXE OFFICE SPACE**: For lease within medical/dental complex. Ideal location in far northwest Cook County. Close to new 315 bed hospital. Over 12,000 square feet of fully equipped, modern suites now available with pharmacy, X-ray, and laboratory facilities. Large waiting area, receptionist, parking. Call 830-1900.

**NILES, ILLINOIS**: For Sale—Modern, prominently located, well maintained medical building, 4650 sq. ft. of exceptionally well planned space. X-ray, emergency room, etc. Very adequate parking. Ideal for group practice. Financing available. Agent for doctor owner. B. H. Gardner, Callero & Catino Realtors, 967-0555.

**MEDICAL OFFICE SUITE FOR RENT**, Lincoln-Belmont Bldg., Chicago, Ill. 900 sq. ft. available immediately in full service, elevator professional building. Call Gary Solomon, 334-5400.

**MEDICAL CONDOS**. Close to Good Samaritan and Hinsdale Hospitals, 63rd & Cass; Westmont. John H. Doyle, Real Estate. (312) 231-9582.

**BARRINGTON**: Deluxe 800 sq. ft. suites available for any specialty. All independent. Ample parking. Few Min. from Good Shepherd and Suburban Hospital. Reasonable terms. 312-381-5800 or 381-4160.

**FOUR BEDROOM** beautifully furnished bayfront house for rent in Holmes Beach—Sarasota, Florida area. Available Oct, Nov, Dec, Jan, Feb, Mar. of this coming year. No children or pets allowed. \$500.00 a week. References needed. Contact S. A. Zaharokis, M.D. (312) 728-2677.

**SAMPLE TIMESHARING**: Private owner of Treetops At Four Seasons unit on Lake of Ozarks offers August 29 - September 5, 1980 or December 26 - January 2, 1981. 1-3 bedroom unit accommodates 6. Fully furnished. 314-636-2205, evenings.

## MISCELLANEOUS

**TISSUE DIAGNOSTIC SERVICES**, a laboratory specializing in tissue processing and diagnosis. Mailers available free. Address requests to: James Bryant, MD, FCAP, Director, 5415 N. Sheridan, Chicago, Ill. 60640 or call 312-561-0671.

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# Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the fol-

lowing style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.

# EKG

(Continued from page 11)

Answers: 1. B, E 2. A, B, C

The ECG rhythm strip shows atrial tachycardia with variable AV block compatible with digitalis toxicity. In the top strip, the AV conduction is 1:1, and the heart rate is 150 beats/minute. At this point, intravenous propranolol was used to create a greater degree of AV block. The bottom strip shows two consecutive P waves following the eighth QRS. This allows us to calculate the rate of the atrial tachycardia at 150 beats/minute. Atrial tachycardia is frequently associated with digitalis toxicity and is in keeping with the history of drug overdosage. The slight variation in QRS morphology at faster rates in the top strip and after short RR cycles in the bottom strip is due to aberrant intraventricular conduction. The first step in treating digitalis toxicity is discontinuation

of the drug. Successful treatment frequently depends on early recognition of this problem. Propranolol has been very helpful in the treatment of digitalis toxicity. It can be dangerous if excessive AV block or even asystole results, so each individual patient must be carefully titrated with propranolol. Direct current cardioversion is contraindicated in arrhythmias caused by digitalis toxicity because it may cause irreversible ventricular fibrillation. However, in desperate situations it may be tried. Potassium chloride is recommended for control of ectopic tachycardias caused by excess digitalis especially in the presence of hypokalemia. Hyperkalemia and excessive AV block must be watched for. Our patient responded to discontinuation of digitalis, low doses of propranolol, and ECG monitoring in the coronary care unit. ◀

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# REPORT

## FOR *Illinois Physicians*

### Free Standing Ambulatory Surgical Facilities Supported

The Chicago-based Blue Cross and Blue Shield Plan has been a proponent of Free Standing Ambulatory Surgical Facilities since enabling legislation was enacted six years ago. The Plan feels facilities of this type provide a means of controlling health care costs without sacrificing patient needs.

There are now six such facilities which have been approved for Plan affiliation and in operation. They are: Northwest Surgicare in Arlington Heights; Hugar Surgery Center in Elmwood Park; Forest Hills Surgical Center, Justice; Hinsdale Surgical Center, Hinsdale; Notre Dame Hills, Belleville, and Surgicare Center, Chicago Heights.

The Plan's policy, prior to enactment of the legislation, was that ambulatory surgery should take place within licensed hospitals, with hospitals making special arrangements to facilitate the care of these patients.

As hospitals began to expand their surgical programs to include procedures that could be performed safely on an ambulatory basis, the Plan encouraged the development of these programs.

Each new free standing facility approved by the Plan has a contract that includes a Procedure List and Charge Schedule for surgery and operating room services, necessary tests and x-rays.

Blue Cross and Blue Shield members having surgery performed at any of the free standing facilities are eligible to receive outpatient surgical benefits in accordance with provisions of benefit programs.

A free standing ambulatory surgical facility wishing to affiliate with Health Care Service Corporation as a member facility shall submit evidence that the facility and its staff does and will comply with the following minimum standards and agrees to periodic evaluation by Health Care Service Corporation to confirm continued compliance.

1. At such time as a plan for free standing ambulatory surgery facilities is adopted by the Illinois Health Facilities Planning Board and/or individual Health Systems Agencies, facilities desiring a contractual relationship with Health Care Service Corporation shall be subject to the approval of such agencies.
2. The facility shall be accredited or shall have applied for accreditation by the Joint Com-

mission on Accreditation of Hospitals, or similar accreditation body.

3. The facility shall be licensed as an ambulatory surgical facility by the appropriate governmental licensing body.
4. The facility shall not provide overnight care of patients within the facility.
5. The facility shall have permanent modern facilities and equipment consistent with the type of care that will be rendered, which shall meet appropriate governmental requirements for fire and safety and sanitation and satisfactory operating procedures to protect the welfare of patients, visitors, employees, and the medical staff.
6. The facility shall include, at least, an operating room, a recovery room, anesthesia and clinical laboratory services adequate for the management of ambulatory surgery cases. Complete radiology, clinical laboratory and other services need not be included in the facility but must be available through a formal arrangement between the facility and a hospital and/or other health care facility recognized by Health Care Service Corporation.
7. The facility shall have emergency equipment available to handle emergencies that may arise during the course of treatment of its own patients. Such equipment shall include but need not be limited to:
  - a defibrillator
  - a tracheostomy set
  - cardio-pulmonary resuscitation equipment
8. There shall be evidence that there is an identifiable governing authority which has assumed legal and moral responsibility for the operation of the facility. There shall also be evidence that the governing authority has delegated authority to an individual or individuals for day to day operation of the facility in accordance with written policy statements that have been adopted by the governing authority.
9. The facility shall have an organized medical staff to which the governing authority has

*(Continued on following page)*

delegated responsibility for maintaining proper standards for medical and surgical care. The medical staff shall have adopted rules and requirements which cover such matters as:

- Criteria and procedure for admission of physicians to the staff.
- Criteria and procedure for determining the extent of medical and surgical privileges.
- Content and form of medical records.
- Procedure for the review of clinical work.

The medical staff shall have established and documented an active utilization review program to insure control over the quality and appropriateness of medical and surgical care. In addition, the staff shall have a functioning Tissue Committee.

There shall be evidence that members of the medical staff have staff privileges with a hospital or hospitals affiliated with Health Care Service Corporation. The privileges accorded individual members of the medical staff shall not exceed the privileges which have been extended to individual members of the staff by hospitals affiliated with Health Care Service Corporation.

10. The governing authority and the medical staff of the facility shall have developed and adopted a statement of the specific procedures which may be performed within the facility.
11. Each patient who is treated in the facility shall be admitted by authority of a member of the medical staff and the care of the patient shall remain under the supervision of the admitting physician or be transferred to another member of the medical staff. Adequate medical records shall be maintained for each patient containing at least the following:
  - Admitting diagnosis
  - Report of medical history and physician examination
  - Laboratory test results
  - X-ray reports
  - Operative reports
  - Anesthesia records
  - Pathology reports of tissue specimens
  - Medications and care ordered and given
  - Discharge summary

The medical staff and governing authority shall adopt an operating policy which states that no patient shall be subjected to surgical treatment until the patient's medical record contains at least a medical history, report of physical examination and appropriate test results, except in emergency.

12. The facility shall show evidence that there is an adequate employee staff including registered professional nursing personnel. There shall also be evidence that at least one physician is on the premises at all times when patients are under care. Anesthesia service shall be performed by a qualified anesthesiologist or by a certified registered nurse anesthetist

under the direct supervision of an anesthesiologist.

13. The facility shall have a written transfer agreement, or other suitable arrangements, with one or more general hospitals affiliated with Health Care Service Corporation to provide emergency and inpatient hospital care under the supervision of a member of its medical staff. Such hospitals shall be within reasonable distance to facilitate the prompt transfer of patients requiring hospital care.
14. Payments for services rendered to Health Care Service Corporation members in the facility shall be subject to cost reconciliation or prospective rate formulas and other controls and shall be documented in a contract between Health Care Service Corporation and the facility.

## Schedule — Fall 1980

### Medical Assistants Workshop

The Fall series of Blue Shield-sponsored daytime workshops for medical assistants in the Chicago metropolitan area begin Sept. 3 and will continue through Nov. 12, 1980.

The workshops are intended to inform medical assistants of Blue Shield administrative, claims and payment procedures and advise them of changes in Blue Shield benefits and contracts.

Letters of invitation are being sent to physician's offices with the reservation forms. For additional information, please write Mr. Bill Livingston, Professional Relations Department, Blue Shield Plan, 233 North Michigan Avenue, Chicago, Illinois 60601, or call him at (312) 661-4488.

Following is a schedule of workshops:

Wednesday Sept. 3, 1980	Ramada O'Hare Inn Mannheim Road & Higgins Park	Schiller
Wednesday Sept. 10, 1980	Holiday Inn 17100 South Halsted	Harvey
Wednesday Sept. 17, 1980	Sheraton Towers 9333 South Cicero	Oak Lawn
Thursday Sept. 18, 1980	Sheraton Towers 9333 South Cicero	Oak Lawn
Wednesday Oct. 1, 1980	Holiday Inn 1501 Sherman	Evanston
Wednesday Oct. 8, 1980	Holiday Inn 3405 Algonquin Road	Rolling Meadows
Wednesday Oct. 15, 1980	Holiday Inn South A.M. I-80 at Larkin Road ONLY	Joliet
Wednesday Oct. 22, 1980	Pheasant Run North Avenue Rt. 64	St. Charles
Thursday Oct. 23, 1980	Pheasant Run North Avenue Rt. 64	St. Charles
Wednesday Oct. 29, 1980	Sheraton Waukegan Inn 200 North Green Bay Road	Waukegan
Wednesday Nov. 5, 1980	Holiday Inn City Centre 300 East Ohio	Chicago
Thursday Nov. 6, 1980	Holiday Inn City Centre 300 East Ohio	Chicago
Wednesday Nov. 12, 1980	McCormick Inn 23rd at the Lake	Chicago





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# Abstracts of Action

June 28-29, 1980

Arlington Heights

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## ADMINISTRATIVE/FINANCIAL MATTERS

Acting on financial matters, the Board:

- Approved a balanced ISMS 1980 revised budget reflecting anticipated income and expense of \$2,398,308. The mid-year revision eliminated a \$112,388 deficit projected at the beginning of the fiscal year.
- Extended to the Society's AMA delegates and alternate delegates the \$100,000 accidental death and dismemberment insurance coverage currently afforded other ISMS officers.
- Voted to: (1) Cap ISMS Benevolent Fund capital assets at \$500,000--allocations previously earmarked to increase the capital will be directed into ISMS contingency and permanent reserves. Fund earnings, ISMS dues allocations and Auxiliary contributions are expected to be sufficient to sustain program outlays; and (2) Urge the Educational & Scientific Foundation's Board to authorize consolidation of several outdated funds within the Foundation into three funds: Post Graduate Medical Education, Publication Improvement, and General.
- Approved sponsorship of a new group term life insurance program for ISMS members. The guaranteed renewable, non-cancellable plan offers coverage ranging from \$25,000-\$1 million.
- Approved increases—ranging from 8%-12%—in *Illinois Medical Journal* black and white advertising rates effective January 1. In addition, the Board authorized a special 10% discount combination package rate for pharmaceutical advertisers.
- Authorized ISMS to seek renewal of a grant from the IDMHDD Division of Alcoholism to support membership education concerning diagnosis, treatment and prevention of alcoholism. This would be the third grant renewal.
- Authorized purchase of a telephone recorder/answering machine to enhance the effectiveness of the ISMS Key Man Program. The equipment will allow Key Men to receive up-to-date legislative information on weekends and after normal business hours as well as report on their contacts with legislators.

## SPECIAL PROGRAMS/PROJECTS

Acting on requests involving special programs and projects, the Board voted to:

- Co-sponsor with the SIU School of Medicine its second annual Physician's Practice Opportunity Job Fair, Sept. 10, in Springfield . . . and invite the Illinois Association of Osteopathic Physicians and Surgeons to co-sponsor the 8th annual ISMS Doctors Job Fair being planned for August or September in Chicago.

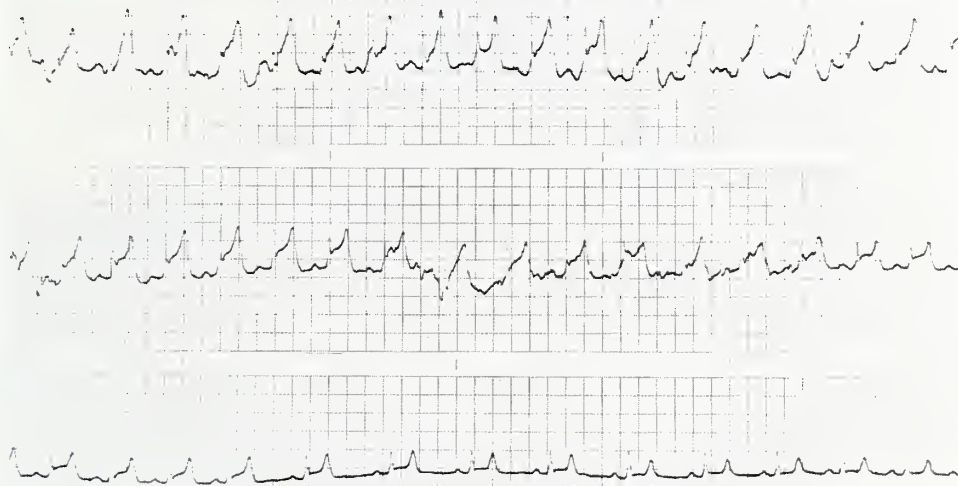
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# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a forty-eight year old man who gave a ten year history of chest pain. The pain was retrosternal and radiated to his neck. It never occurred with exertion nor was it predictable. It would occur at rest during the day and was always relieved by sublingual nitroglycerin. Five years ago, gastrointestinal tract X-rays and a cholecystogram were normal. A coronary angiogram was performed at that time and demonstrated mild fixed coronary obstructive disease. Subsequently the patient had a normal exercise ECG, running for 13 minutes on the treadmill by the Bruce protocol. He did not develop chest pain on the treadmill. A combination of long and short-acting nitrates allowed the patient nearly complete relief of the chest pain. Recently the chest pain increased in frequency to several times a day. The pains were not exertional, nocturnal, or post-prandial. Occasionally more than one sublingual nitroglycerin tablet would be required for relief of the pain. A twenty-four hour Holter monitor ECG recording was obtained. The ECG strip shown occurred during a chest pain.*



## Questions:

### 1. The ECG rhythm strip shows:

- A. An accelerated idioventricular rhythm.
- B. Cycle dependent or rate related bundle branch block.
- C. ST segment elevation with sinus rhythm.
- D. A short burst of atrial tachycardia.
- E. None of the above.

### 2. The following statement (s) is/are true:

- A. The patient has Prinzmetal's variant angina.
- B. Patients with variant angina may have a normal exercise ECG.
- C. Variant angina can occur in patients with normal coronary arteries as well as coronary arteries with severe atherosclerotic obstructive disease.
- D. Cardiac arrhythmias can occur in patients with variant angina.
- E. All of the above.

(Continued on page 100)



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**Precautions:** Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

**Dosage and Administration:** Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

**Anusol-HC Cream — Adults:** After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

**NOTE:** If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

**How Supplied:** Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C). Full information is available on request.

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2/80



# The Viewbox

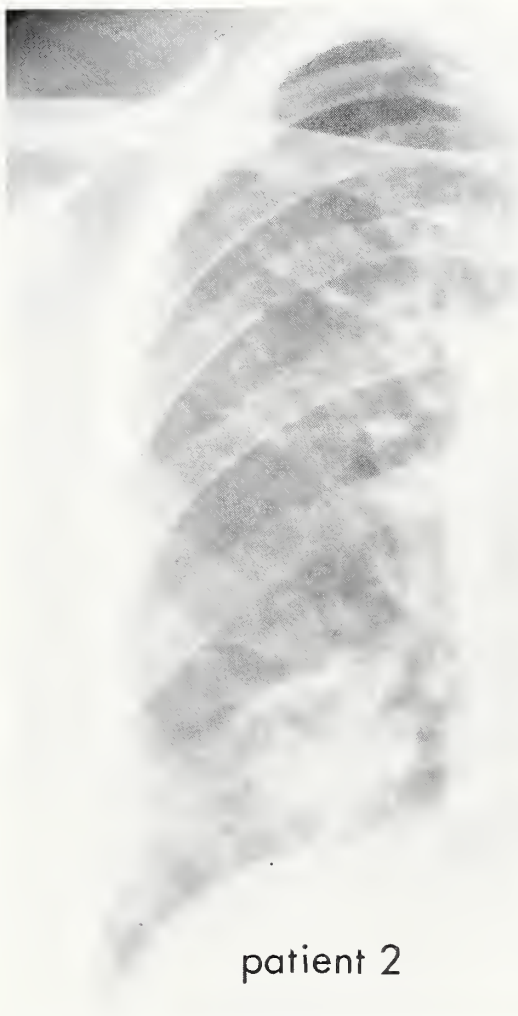
Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

These two patients have the same diagnosis. Patient 1 has a cough, dyspnea, and chronic constipation. Patient 2 is asymptomatic.



patient 1

**Figure 1**  
PA Chest—Patient 1



patient 2

**Figure 2**  
Close Up Right Lung—Patient 2

## *Your diagnosis?*

1. Bronchiolar carcinoma
2. Lipoid pneumonia
3. Tuberculosis
4. Fungal infection
5. Pseudolymphoma

*(Continued on page 85)*



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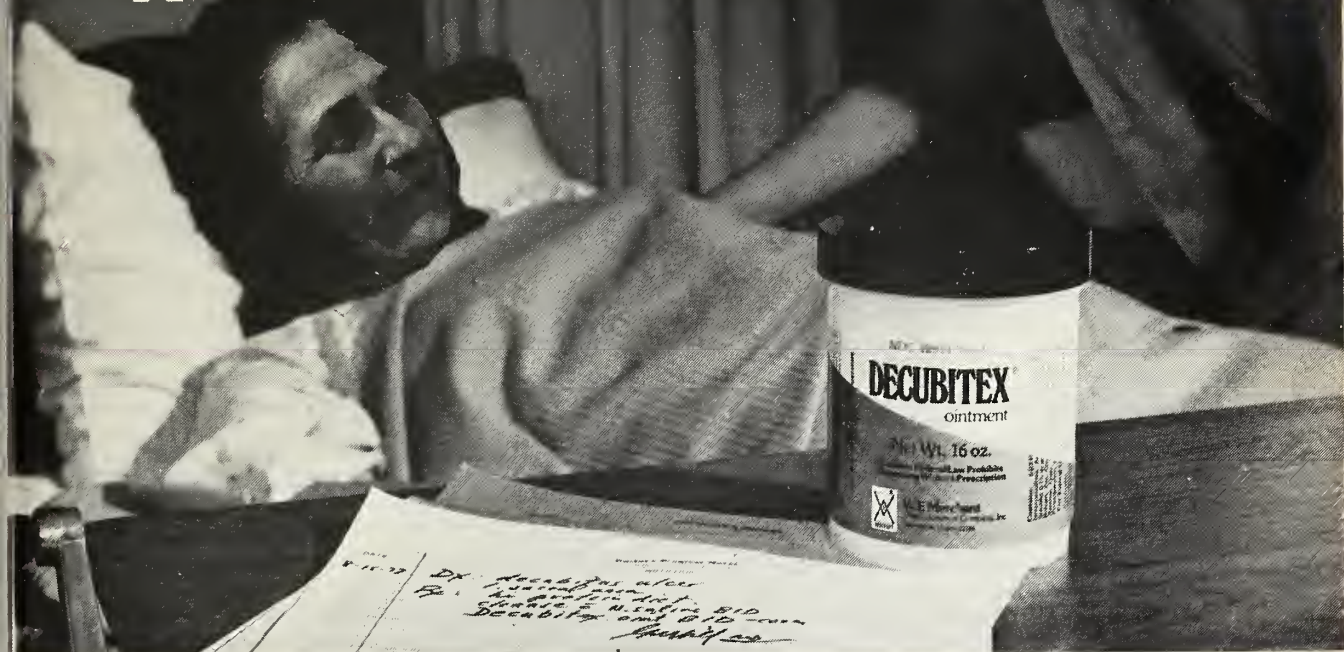
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## Clinics For Crippled Children Listed For September

Forty clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 11 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Park Ridge Cardiac (a.m.)—Lutheran General Hospital
- 2 Park Ridge General (p.m.)—Lutheran General Hospital
- 2 Wheaton General—Marianjoy Rehab. Hosp.
- 3 Hinsdale—Hinsdale Sanitarium
- 4 Sterling—Community General Hospital
- 4 Lake County Cardiac—Victory Memorial Hospital
- 4 Effingham—St. Anthony Memorial Hospital
- 5 Division Cardiac—U. of I. at the Medical Center
- 8 Peoria Cardiac—St. Francis Hospital
- 8 Chicago Heights Cardiac—St. James Hosp.
- 9 Peoria General—St. Francis Hospital
- 9 Carrollton—Boyd Memorial Hospital
- 9 Alton—Alton Memorial Hospital
- 10 Joliet—St. Mary's Hospital
- 10 Chicago Heights General—St. James Hosp.
- 10 Carmi—Carmi Township Hospital
- 10 Rock Island CP—Foundation for Crippled Children and Adults
- 10 Champaign-Urbana—McKinley Hospital
- 11 Aurora Cardiac—Mercy Center for Health Care Services
- 11 Springfield General—St. John's Hospital
- 16 Belleville—St. Elizabeth's Hospital
- 16 Rock Island Area General—Moline Public Hospital
- 16 Decatur—Decatur Memorial Hospital
- 16 Maywood—Loyola Medical Center
- 17 Springfield Ped-Neuro-St. John's Hosp.
- 17 Evergreen Park—Little Co. of Mary Hosp.
- 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 18 Rockford—Rockford Memorial
- 18 Centralia—St. Mary's Hospital
- 19 Kankakee Cardiac—St. Mary's Hospital
- 22 Chicago Heights Cardiac—St. James Hosp.
- 22 Peoria Cardiac—St. Francis Hospital
- 23 Peoria General—St. Francis Hospital
- 23 Maywood General (half-day, ortho only) Loyola Medical Center
- 24 Elgin General—Sherman Hospital
- 24 Chicago Heights General—St. James Hosp.
- 24 West Frankfort—UMWA Union Hospital
- 25 Macomb—Medical Bldg. of McDonough District Hospital
- 25 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 30 East St. Louis—Community Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## Obituaries

**\*Bonebrake, Harold V.**, Chicago, died June 22, 1980, at the age of 71. Dr. Bonebrake was a 1933 graduate of Northwestern University Medical School.

**\*\*Clark, Daniel E.**, Chicago, died July 9, 1980, at the age of 89. Dr. Clark was a 1922 graduate of Loyola University Stritch School of Medicine.

**\*Drummond, Selwyn H.**, Kankakee, died June 16, 1980, at the age of 66. Dr. Drummond was a graduate of the Ohio State University College of Medicine.

**\*Feinhandler, Emanuel J.**, Chicago, died June 26, 1980, at the age of 76. Dr. Feinhandler was a 1934 graduate of the University of Illinois Medical School.

**\*Hoban, Thomas J.**, Elgin, died July 4, 1980, at the age of 57. Dr. Hoban was a 1947 graduate of the University of Illinois Medical School.

**Malony, William R.**, Carbondale, died June 16, 1980, at the age of 67. Dr. Malony was a 1938 graduate of University of Nebraska College of Medicine.

**\*\*Smith, Louis D.**, Chicago, died June 23, 1980, at the age of 92. Dr. Smith was a 1911 graduate of Rush Medical College.

**\*\*Stromberg, William B.**, Chicago, died June 27, 1980, at the age of 86. Dr. Stromberg was a 1920 graduate of the University of Illinois Medical School.

**\*\*Sweeney, William**, Chicago, died June 25, 1980, at the age of 94. Dr. Sweeney was a 1922 graduate of Loyola University Stritch School of Medicine.

**\*\*Zimmerman, Leo, M.**, Chicago, died June 28, 1980, at the age of 82. Dr. Zimmerman was a 1923 graduate of Rush Medical College.

\* Indicates ISMS member

\*\*Indicates ISMS member of the fifty year club



# Illinois Housestaff News

## Collective Bargaining—A Mutual Benefit

Life as a house officer has come a long way from the time they lived and ate in the hospital, receiving only a small amount of spending money in return for a 120-hour work week. Harsh conditions similar to these were dramatized nationwide when New York's Committee on Interns and Residents walked out for four days beginning March 17, 1975, affecting about 10% of New York City's hospital beds. At issue were the excessive number of hours worked per week (often 100+) and number of continuous hours (40-50), along with pay increases and other benefits.

Perhaps one of the big boosts to the strike occurred on the second day, March 18, when the AMA issued a statement that lent credence to the numerous complaints and disputes which precipitated the strike. The statement said that "the AMA does not believe a physician has the right to strike against a patient. It is evident the Committee of Interns and Residents believes that too." Further, it was noted that "when a physician has to work 50 hours straight or 100 hours a week it is not only tough on him or her, it is also a threat to quality of care the patient is receiving."

The resolution of the strike giving a decrease in hours, increase in pay and other benefits resulted in an enormous ripple effect throughout the country's house staff, finally recognizing their right to collective bargaining. In Chicago, James Houghton, M.D., then head of the Cook County Hospital's administration, allowed the hospital's

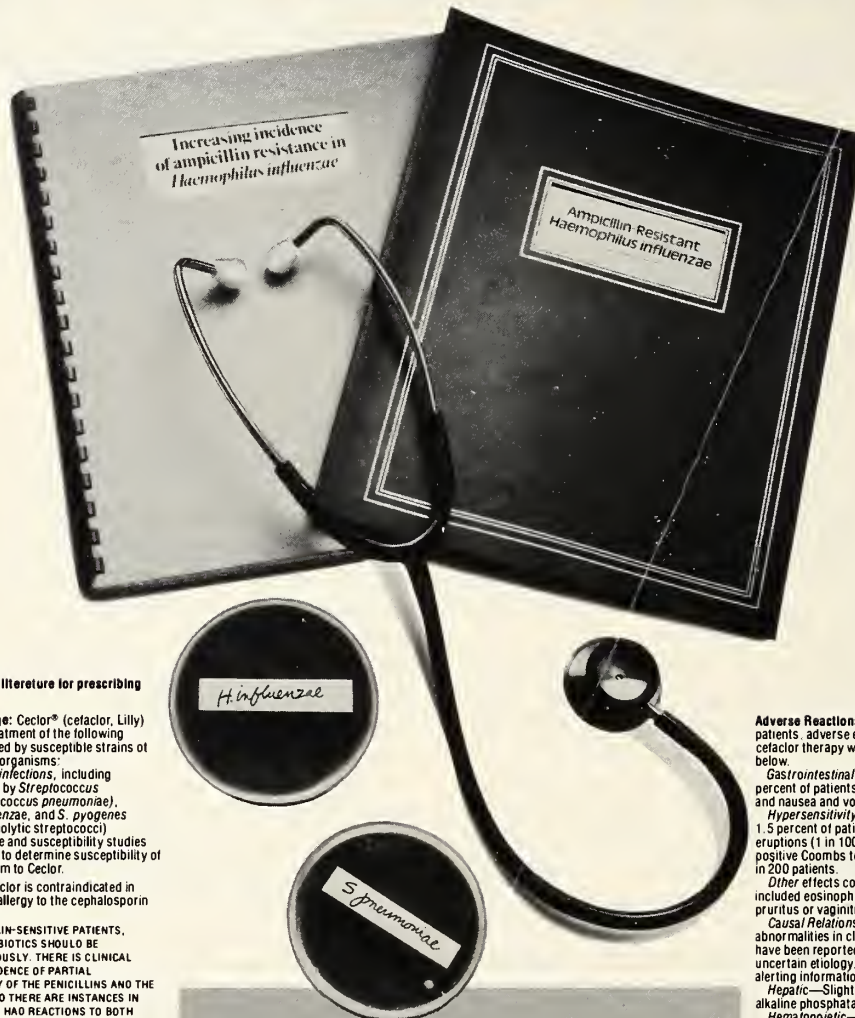
housestaff to elect an official collective bargaining agent. However, at the same time, several other major medical centers in Chicago were hindering the attempts of their housestaff to establish collective bargaining status. In the years since, we as house officers have seen the formation of housestaff organizations in many major medical centers throughout the state. Collective bargaining has resulted in contracts which have improved working conditions in most centers. At one medical center, over a period of years, many benefits have been achieved, such as: annual pay increases, extra compensation for excessive call, broad medical and dental coverage, educational leave at all levels, unlimited sick pay, meal reimbursement, due process for grievances. These benefits, instituted by active participation of housestaff in their contractual arrangements, now are in effect at most hospitals in the state. The conditions set up by such agreements become mutually beneficial for all by leading to better and more efficient patient care. ◀

Brad L. Epstein, M.D.  
Secretary/Editor

### References

1. AM News, May 5, 1975.
2. AM News, March 24, 1975.
3. New York Times: Feb. 17-March 29, 1975.

# An added complication... in the treatment of bacterial bronchitis\*



**Brief Summary.** Consult the package literature for prescribing information.

**Indications and Usage:** Cefaclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

**Contraindication:** Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematology studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

**Usage in Pregnancy:** Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy:** Safety of this product for use in infants less than one month of age has not been established.

**Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefaclor.<sup>1-6</sup>**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.<sup>7</sup>

## Cefaclor®

### cefaclor

Pulvules®, 250 and 500 mg

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

**Note:** Cefaclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

#### References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.



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# IMJ

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## Advice for the Dispensing Physician

By MARTIN I. BLAKE, Ph.D. and LAWRENCE B. SLOTNIK/CHICAGO

*The dispensing physician must be aware of legal requirements specified in various federal and state Acts (and their rules and regulations) as they pertain to the proper labeling, storage, and packaging of drug products. He must also be cognizant of record-keeping requirements involving controlled substances. This article attempts to update the dispensing physician in this regard.*

The Illinois Pharmacy Practice Act (PPA)<sup>1</sup> regulates all aspects of the practice of pharmacy in the State of Illinois. Section 4 of the PPA states in part:

*"Nothing contained in any section of this Act shall apply to, or in any manner interfere with;*

*(a) the lawful practice of any physician, dentist, veterinarian or allied medical practitioner, or prevent him from supplying to his bona fide patients such drugs, medicines, or poisons as may seem to him proper."*

**Martin I. Blake, Ph.D.**, is Professor of Pharmacy in the College of Pharmacy, University of Illinois at the Medical Center, Chicago, and is a member of the Illinois Board of Pharmacy.

**Lawrence B. Slotnik, B.S.**, is Drug Compliance Coordinator in the Department of Registration and Education, State of Illinois.

Thus, it is clear from this section of this Act that the physician may in the course of his practice administer and dispense medications; but when he does assume the role of a "dispensing physician," he must be aware of and conform to all legislation that pertains to the dispensing of medications. Such legislation appears in the Federal Food, Drug, and Cosmetic Act (FDCA);<sup>2</sup> the State and Federal Controlled Substance Acts (CSA);<sup>3,4</sup> and the State Medical Practice Act (MPA).<sup>5</sup> He also must comply with Rules and Regulations promulgated for administration of the various acts, and in particular with the Code of Federal Regulations (CFR) as it pertains to the Federal CSA. This article seeks to review the points of law and those regulations which deal with labeling, packaging, storage, and record-keeping in dispensing medications.

In regard to labeling requirements, the following section of the MPA delineates the specific

information which is to appear on the prescription container label:

**"Sec. 2d. Dispensing drugs or medicine—label.)** *Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such a drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names [sic] of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug, and Cosmetic Act and the Illinois Food, Drug, and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. 'Drug' and 'medicine' have the meaning ascribed to them in the 'Pharmacy Practice Act'."*

The Illinois CSA, Section 312 (f) states:

*"Whenever a practitioner dispenses any controlled substance, he shall affix to the container in which such substance is sold or dispensed, a label which conforms to Federal BNDD [DEA] requirements. No person shall alter, deface or remove any label so affixed."*

DEA requirements referred to in this section appear in the CFR (Section 1306.24). However, a careful reading of the CFR section reveals that the requirements are directed to the pharmacist and not to the dispensing physician. Thus, it is our interpretation that "practitioner" as used in the Illinois CSA [312 (f)] refers only to the pharmacist. This notwithstanding, labeling requirements cited in Section 2d of the MPA, as cited above, do pertain to the dispensing physician. There is an apparent discrepancy in the definition of "practitioner" as cited in the CFR and as referred to in the Illinois CSA [102 (kk)].

Section 312 of the Illinois CSA concerns all aspects of "dispensing controlled substances." Dispensing physicians are, of course, expected to meet the requirements of this section in the same manner as are dispensing pharmacists (with the exception of certain aspects of recordkeeping as

noted here). With respect to Schedule V substances, the physician is not required to obtain and maintain the same detailed information as required by the pharmacist, but *he, the physician, must keep a record of what is dispensed*. As is true for all controlled substances, Schedule V substances can only be dispensed for legitimate medical purposes. Section 312(d) deals specifically with the keeping of records of controlled substances. It has recently been amended by the legislature through passage of P.A. 81-488 (effective Jan. 1, 1980) and now reads:

*"(d) Every practitioner shall keep a record of controlled substances received by him and a record of all such controlled substances administered, dispensed, or professionally used by him otherwise than by prescription. It shall, however, be sufficient compliance with this paragraph if any practitioner utilizing controlled substances listed in Schedules III, IV, and V shall keep a record of all those substances dispensed and distributed by him other than those controlled substances which are administered by the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means to the body of a patient or research subject."*

Previously, according to Section 312(d) the physician was not required to keep "a record of the amount of such solution or other preparation administered or dispensed to individual patients." *This is no longer true* according to the amended section. The dispensing physician is urged to carefully note the wording change of this paragraph in view of the fact that he is required to maintain records of all Schedule II controlled substances administered, dispensed or otherwise professionally used in the course of his medical practice *other than by prescription*. All records of the dispenser must be readily retrievable when requested by the appropriate authorities.

Section 312(c) (8) of the Illinois CSA limits the quantity of Schedule V controlled substances which may be kept in stock by the dispenser to 4.5 liters for each substance. Schedule V controlled substances are, in general, the over-the-counter narcotic cough preparations.

For Schedule II controlled substances which are "designated products," the official triplicate prescription blank must be used. When such designated products are dispensed by the physician, the original prescription must be kept on file and the duplicate copy mailed to the Department of



Registration and Education (DRE) by the 15th of the following month. This is now mandated by P.A. 81-872 (effective Jan. 1, 1980), Section 312(d), which has been amended further to read:

*"A practitioner who dispenses, other than by administering, a controlled substance in Schedule II, which is a narcotic drug listed in Section 206 of this Act [the Illinois CSA], or which contains any quantity of amphetamine or methamphetamine, their salts, optical isomers or salts of optical isomers, pentazocine, methaqualone, or which is hereafter determined to be a "designated product" as defined in Section 102 of this Act [the Illinois CSA], shall do so only upon the issuance of an official prescription blank; and every practitioner who so dispenses such designated products shall comply with the provisions of sections 310 and 311 of this Act [the Illinois CSA]."*

Section 306 of the Illinois CSA requires every practitioner and person registered to dispense controlled substances under this Act to keep records and maintain inventories in conformance with recordkeeping and inventory requirements of the laws of the United States and with any additional rules and forms issued by the DRE. Failure to comply is regarded as a Class A misdemeanor.<sup>6</sup>

Section 1304.03 of the CFR (Federal Regulation) titled "Persons required to keep records and file reports," contains the following pertinent subparagraphs:

*"(b) A registered individual practitioner is not required to keep records with respect to narcotic controlled substances listed in Schedules II through V which he prescribes or administers in the lawful course of his professional practice; he shall keep records, however, with respect to such substances that he dispenses other than by prescribing or administering.*

*(c) A registered individual practitioner is not required to keep records with respect to non-narcotic controlled substances listed in Schedules II through V which he dispenses in any manner unless he regularly charges his patients, either separately or together with charges for other professional services, for such substances so dispensed (e.g., when he substitutes his services for those of a pharmacist)."*

It should be emphasized that P.A. 81-488 now imposes more stringent recordkeeping requirements on the dispensing physician.

Subsequent sections of the CFR deal very explicitly with the requirements for proper maintenance

of records and inventories. Space does not permit the full reproduction here of all the specific details listed in the CFR, but the federal regulations may be obtained by writing: The Superintendent of Documents, US Government Printing Office, Washington, DC 20402. Request the Code of Federal Regulations, 21 Food and Drugs (Part 1300 to End—Revised as of April 1, 1979).

In general, each registered dispenser is required<sup>7</sup> to maintain all invoices, the biennial inventory, and other records pertaining to controlled substances for a period of two years. When a controlled substance is dispensed, he is required to record the following: the name of the controlled substance, the dosage form (e.g., 10 mg tablet) and the number of units or the volume of a liquid dispensed, the name and address of the person to whom it was dispensed, the date of dispensing, and the written or typewritten name or initials of the individual who dispensed the substance on behalf of the dispenser.

The Illinois Poison Prevention Packaging Act (PPPA) of 1970<sup>8</sup> requires that all prescription drugs be dispensed in "special packaging" (child-resistant containers) with certain specified exceptions. The PPPA defines "special packaging" in the following way:

*"Sec. 2.04 "Special packaging" means packaging that is designed or constructed to be significantly difficult for children under 5 years of age to open or obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for normal adults to use properly, but does not mean packaging which all such children cannot open or obtain a toxic or harmful amount within a reasonable time."*

An exception to this is indicated in Sec. 4(b) of the PPPA which states:

*"In the case of a household substance which is subject to such a standard and which is dispensed pursuant to an order of a physician, dentist, or other licensed medical practitioner authorized to prescribe, such substance may be dispensed in non-complying packages only when directed in such order or when requested by the purchaser."*

Dispensing physicians are required to comply with the provisions of the PPPA. However, where a physician determines that a particular patient's situation so warrants, a non-complying or conventional container may be utilized for dis-

dispensing medications.

For drugs and drug dosage forms listed in the official compendia (United States Pharmacopeia-National Formulary),<sup>9</sup> one must comply with monograph specifications for packaging, storage, and labeling. Specifications for packaging are designed to assure that the dispensing container will maintain the identity, strength, quality, and purity of the drug product at least throughout the period of time that the drug product is to be used. For example, the monograph may specify that a well-closed or tight container or a light-resistant container be used when the particular drug is dispensed. "Containers" are clearly defined in the General Notices section of USP XX-NFXV (p. 7). Specific directions are also stated in the appropriate monographs regarding the temperature at which compendial articles are to be stored, where it has been determined that storage at a lower or a higher temperature may produce untoward effects. The compendia specify the temperature ranges for storage conditions designated as cold, cool, room temperature, warm, and excessive heat. The dispensing physician is cautioned that it is a violation to dispense medications in envelopes or in cardboard containers. All dispensed medications must be labeled in accordance with the several Acts mentioned earlier.

Effective February, 1980, drug manufacturers were required to include in the package labeling a statement to the dispenser describing the type of container necessary to assure the maintenance of identity, strength, quality and purity of each prescription drug product. Products intended to be dispensed in the manufacturer's original container will be exempt from this requirement. This regulation appeared in the Federal Register August 25, 1978. While at the present time the Federal FDCA [Section 502(g)] requires that prescription medications be dispensed in defined containers, the new regulation will require manufacturers to include on their drug product labels an instruction to the dispenser regarding the appropriate type of container for repackaging the drug product.

Drug manufacturers are required by law to include on the container label an expiration date assigned for the particular formulation and package of the drug product. This date indicates the time during which the product may be expected to meet the requirements of the compendial monograph, assuming that it has been kept under the prescribed storage conditions. The expiration date is an indication of the time during which the

product may be used with the expected effectiveness. The dispensing physician, as well as the dispensing pharmacist, must adhere to the packaging and storage requirements if the patient is to be assured of maximum therapeutic effect of the drug being prescribed.

Physicians licensed in the State of Illinois are reminded that when a violation of Section 16 of the MPA has been established, the Department of Registration and Education has the authority to:

*"revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license----."*

Violations involving labeling, storage, and recordkeeping may come under items 4 and 12 of Section 16:

*"(4) Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;*

*"(12) A violation of any provision of this Act or of the rules and regulations for the administration of this Act."*

In Addition, item 21 of the grounds for discipline states in part:

*"(21) Willful omission to file or record . . . medical reports as required by law."*

In summary, the dispensing physician is reminded that there are legal requirements pertaining to the proper labeling, storage, and packaging of drug products. These are specified in the various federal and state statutes and their rules and regulations. The dispensing physician must also be aware of the changes in record-keeping requirements involving controlled substances. The authors invite comments from physicians, particularly those who dispense medications. ◀

## References

1. Ill. Rev. Stat. 1977, ch. 111, Sec. 4001 *et seq.*
2. 52 Stat. 1040
3. Ill. Rev. Stat. 1977, ch. 56½, Sec. 1100 *et seq.*
4. P.L. 91-513
5. Ill. Rev. Stat. 1977, ch. 111, Sec. 4401 *et seq.*
6. Ill. Rev. Stat. 1977, ch. 56½, Sec. 1406(a).
7. CFR, Title 21: Sec. 1304.24
8. Ill. Rev. Stat. 1977, ch 111½, Sec. 291 *et seq.*
9. Licensed pharmacies in Illinois are required to have the current editions of the official compendia.



# Controlled Substances Reference Chart<sup>®</sup>

*The following chart has been supplied by the Illinois Pharmacists Association for reference. Additional copies of the chart, including a complete chart of commonly prescribed drugs and their control status may be obtained by writing the Illinois Pharmacists Association, 222 W. Adams Street, Chicago, IL 60606.*

	Federal Schedule Number	Requires Of- ficial State Triplicate Rx	Requires Written Rx Signed by MD	Refill Status	Federal Order Form Required
<b>Old Class "A" Narcotics</b> (Morphine, Demerol, Dilaudid, etc.)	II	YES	YES	NO	YES
<b>Methamphetamines and all combinations.</b> (Desoxyn, etc.)	II	YES	YES	NO	YES
<b>Amphetamines and combinations.</b> (Dexedrine, Eskatrol, Bamadex, etc.)	II	YES	YES	NO	YES
<b>Methaqualone.</b> (Quaalude, Sopor, Parest, etc.)	II	YES	YES	NO	YES
<b>Methylphenidate</b> (Ritalin)*	II	NO	YES	NO	YES
<b>Phenmetrazine</b> (Preludin)	II	YES	YES	NO	YES
<b>Injectable &amp; oral forms of amobarbital, pentobarbital, &amp; secobarbital, all combinations with each other and with other controlled drugs.</b> (Tuinal, etc.)	II	NO	YES	NO	YES
<b>Old Class "B" Narcotics</b> (Empirin, Codeine, Hycomine, Phenaphen with Codeine, etc.)	III	NO	phone orders acceptable	5 times or 6 months as indicated by prescriber	NO
<b>Schedule III drugs</b> (Sanorex, Voranil, Plegine, Butabarbital, Paregoric, Mediatric, Phenlantan, Gemonil, Doriden, etc. Also Nembutal and Seconal Suppositories)	III	NO	phone orders acceptable	5 times or 6 months as indicated by prescriber	NO
<b>Schedule IV drugs</b> (Librium, Valium, Tenuate, Tepanil, Ionamin, Phenobarbital, Meprobamate, Darvon, etc.)	IV	NO	phone orders acceptable	5 times or 6 months as indicated by prescriber	NO

\*State Schedule III

# Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

## Raynauds: Disease vs. Phenomenon

A 29-year-old Mexican housewife was seen for color changes in her hands. Four months before she had noted that, upon exposure to cold, her fingertips would turn white, then blue. On re-warming, the fingers occasionally became fiery-red before returning to their original color. Color changes were associated with finger pain, tingling and sometimes burning, which often spread to the dorsum of her hands. Attacks occurred several times a day, lasting 10 to 15 minutes, and were precipitated by slight exposures such as touching the refrigerator or washing in cool water. Her toes had been similarly involved. Over the ensuing months, her fingers had taken on a purplish hue which persisted between the attacks.

The patient was otherwise in good health. She was on no chronic medications, and past history revealed only two uncomplicated pregnancies. She denied joint pains, skin changes, sun sensitivity, alopecia, pleurisy, dysphagia, mucosal ulcerations or change in bowel habits. The patient was a non-smoker. She gave no history of recurrent stress to her hands. Family history was non-contributory.

On examination, vital signs were normal. Inspection of the fingers revealed a bluish discoloration. Tufts of the fingers were soft without trophic changes or ulcers present. Radial, ulnar and brachial pulses were intact. No bruits were heard over the subclavian vessels. Small joints of the hand were unremarkable. Upon exposure to cool running water, the typical color changes described above occurred in all fingers. Cervical spine motion was normal and maneuvers to block the thoracic outlet were unsuccessful. Other examination was unrevealing.

### Laboratory

Hemoglobin was 12.9. Hematocrit was 39.7%.

WBC count was 5100 with a normal differential. SMA 18, urinalysis, EKG and chest X-ray were all within normal limits. RPR was non-reactive. Esophagram revealed only mild reflux present. Good peristalsis was noted throughout its length. Sedimentation rate was 40mm/hr Westergren. Rheumatoid factor by latex was negative. Antinuclear antibodies were present at 1:500 titer in a speckled pattern. LE preps were negative, as were anti-DNA and anti-ENA antibodies. Complement levels were normal. Cryoglobulins and cold agglutinins were not detected in serum. Serum protein electrophoresis and blood viscosity were normal. Skin biopsy showed a normal collagen pattern with no immunoglobulin or complement present by immunofluorescent staining.

### Discussion

Raynauds phenomenon consists of episodic vascular spasm leading to insufficiency in distal extremities, usually precipitated by cold and resulting in color changes of pallor and/or cyanosis. Upon re-warming, a rebound hyperemia occurs, giving the hands a temporary erythematous color. Attacks involve the tips of the digits, spreading to more proximal areas on occasion, and often accompanied by pain and paresthesias. Other acral areas such as toes and, more rarely, tips of nose, tongue or ears may be involved. Precipitating factors include general exposure to cold as in winter, or more local exposure to the hands during daily life. Emotion may be a precipitating factor in up to 25% of attacks. Trophic changes with ulceration and finger tuft atrophy occur late, and true gangrene is rare.

Raynauds phenomenon is generally associated with other conditions. These commonly include the connective tissue diseases, occurring in lupus, rheumatoid arthritis, dermatomyositis and



mixed connective tissue disease as well as scleroderma. In each of these, it may be the presenting sign and predate other disease manifestations by months or years. It has also been associated with vascular occlusion in upper extremity arteries by atherosclerosis, thromboembolic phenomenon, Buerger's disease, thoracic outlet syndromes, crutch-axillary pressure syndrome and carpal tunnel syndrome. Hematologic disorders such as polycythemia, cryoglobulinemia, paraproteinemias, cold agglutininemia or other hyperviscosity states may manifest Raynauds phenomenon. Vasospastic drugs like ergots or methysergide as well as heavy metal intoxication by lead, mercury or arsenic may also cause the phenomenon. Finally, repeated hand trauma has been indicted as a causative factor. This may involve severe vibratory forces as in the use of pneumatic drills or chain saws. Lesser forces may also be involved, such as the recurrent striking of fingers against piano or typewriter keys.

Raynauds disease is isolated Raynauds phenomenon unassociated with other diseases. Differentiation may be difficult, however, because of the insidious onset the phenomenon may have in the diseases associated with it. Evidence for an associated condition must be persistently absent for a period of two years before diagnosis of Raynauds disease can safely be made. History, physical exam and laboratory assessments are aimed at ruling out the causes discussed above.

Raynauds disease may respond to simple avoidance therapy. Exposure to systemic cold should be limited, and where unavoidable, warm clothes should be worn. Cotton gloves worn during daily activities which precipitate attacks may be useful. Relocation to a warm climate may be useful in extreme cases. Drug therapy with oral vasodilators such as alpha methyldopa, phenoxybenzamine or reserpine may be helpful, as may local applications of nitroglycerine ointment. In recalcitrant cases, intra-arterial injections of reserpine have been used with variable success. Sympathectomy may be of benefit, and stellate ganglionic block may help predict its usefulness prior to surgery.

Raynauds phenomenon is treated with similar measures. Correction of the underlying disorder is the primary therapy, however, and should precede more complicated therapies.

## Conclusion

Our patient presented with episodic color changes in her hands suggestive of Raynauds. Despite elevated sedimentation rate and positive anti-nuclear antibodies, there was no evidence of connective tissue disease or other underlying

causes. Because symptoms and suggestive labs were brief, a tentative diagnosis of Raynauds phenomenon was made. The patient was instructed in avoidance therapy and started on alpha-methyldopa orally with some relief of symptoms. Onset of warmer weather during spring markedly decreased frequency and severity of attacks. At follow-up nine months past onset of illness, no underlying cause was manifest. ◀

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1. Allen, E.V. and Brown G.E.: "Raynauds Disease - A Clinical Study of 147 Cases," *JAMA* 99: 1472-1478, 1932.
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*Further bibliography can be obtained on request from the authors.*

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# Special Articles

## Physician Interrelationships With Allied Health Personnel

*Following is the text of a position paper approved by the ISMS Board of Trustees at their June 28-29, 1980, meeting. This is reprinted as a service to the membership.*

### Background/Rationale

Over the years, as technology and education have progressed, and as public demands for personalized services have increased, there have evolved various categories of personnel to meet these needs. In no place is this more evident than provision of health-care services.

To assure the public a high degree of competence in various activities, government has engaged in a licensure process. By this, certain conditions must be met by an individual in order to provide specific services. In addition, within individual professions, accreditation and certification also are accomplished.

Many categories or groups of persons now provide personal services in the health care arena. Each group tries to identify itself as a special or unique assemblage of persons providing a distinct health service, for a variety of reasons. Many have internal certification mechanisms. Several have or seek state licensure.

Universities and major health centers are developing curricula for educating and training non-physician health practitioners to meet a perceived public demand for specialized services. A fragmentation in patient care seems to exist. Individuals are educated, obtain a degree, and then enter the working community as "limited health professionals," which may not, although it should, lead to the desired end product—integrated patient care within the medical model. Expansion of the education system is providing ever-increasing numbers and kinds of persons, highly motivated and with good credentials, who expand into direct patient care without the ability to practice medicine.

All non-physician health professionals need a better understanding of how their functions inter-

relate with others providing care or service. Each must comprehend his unique role, but also should recognize personal limitations as well as lines of responsibility and contributions others can make in resolution of clinical problems. Interrelationships must be established with public benefit in mind. Turf battles, objectivity shortcomings, traditions, and experimental factors must be resolved; fiscal arguments must be put aside, recognizing that no one can function in isolation. This is explicitly true in health care delivery.

Physicians, individually and as a profession, must provide the leadership required to initiate coordination and integration of health care team members. As the person with the highest degree of clinical sophistication, skill and training, with the broadest base for treating the whole man, and with the license provided by the state, the physician must be involved in setting forth functional relationships.

It is in this context that the Task Force on New Health Practitioners has developed this position paper. Areas of activity and lines of authority must be described. Definitional considerations must be addressed. There must be a channeling into appropriate roles with no attempt to curtail or contain activities for which another may be trained, educated, credentialed or licensed. Allowable tasks, within statutory authority, can be set forth and distinctions of specific tasks be drawn.

The ultimate focus of all health care activity is the patient and patient needs. Traditional approaches to isolated health care services or education seem to be giving way to integrated concepts. Pressures by society and allied health



professions are expanding roles of heretofore dependent categories of health care personnel. Academia is stressing the team approach. Cost effective considerations have been proffered.

Thus, it is imperative that the State Medical Society identify a position in many facets of this concern. This will allow development of inter-relationships with allied health professions and express the view of physicians as to the role of persons providing health care services.

## Definitions

### A. Licensure, Registration, Certification

- (1) *Licensure*: an activity in which the state verifies the qualifications and accomplishes testing so as to assure competency.
- (2) *Registration*: a listing of persons who have accomplished certain requirements, there is attestation of qualifications, and proper registration is made by the state.
- (3) *Certification*: a mechanism by which persons in certain categories achieve recognition for competency beyond minimal standards within and by the group of persons similarly practicing. Such certification may or may not be recognized by the state.

Presently the following health professions are regulated in Illinois:

- (1) *Licensed* (all by education requirements, all by testing)
  - Dentists
  - Doctors of Medicine
  - Persons allowed to treat human ailments without the use of drugs or operative surgery
  - Podiatrists
  - Nurse, professional
  - Licensed Practical Nurse
  - Veterinarian
- (2) *Registered* (all by education requirements, some by testing)
  - Optometrist
  - Physical Therapist
  - Pharmacist
  - Psychologist
  - Social Worker
- (3) *Certified* (all by education requirements)
  - Physician's Assistant (and thereby licensed)
  - Dental Hygienist

No other categories of health care allied personnel are regulated by the state through R & E. Of those listed above, only a doctor of medicine is a totally independent, unlimited health care provider. Several are independent and may engage in entrepreneurial activity, but are limited in the scope of their license and ability to treat patients. These include chiropractors, dentists, podiatrists, psychologists, pharmacists, and optometrists. All others are dependent, limited license personnel who function under order of a physician.

### B. Types of Relationships

- (1) A *colleagial* relationship is established between peers, of similar education and licensure stature.
- (2) A *supervisory* relationship exists between a physician and a non-physician (allied health professional) when the physician manages and is responsible for a patient's care as long as the prescribed care or therapy continues under the physician's direction and supervision.
- (3) A *collaborative* relationship exists when a physician and a limited, independent non-physician provide different but complementary functions relating to the patient's care or treatment plan. The physician must provide periodic re-evaluation of the patient's condition through personal examination, so that a revision or continuation of the patient's medical treatment, as clinically indicated, may be instituted.
- (4) A *consultative* relationship exists between peers, or between a physician and a non-physician (allied health professional) when the physician provides advice or opinion regarding a patient's care or treatment on an episodic or continuing basis, recognizing that the physician is responsible for differential diagnosis and management of medical care, which may or may not relate to the professional service being provided by a non-physician.

### C. Responsibility

A physician is responsible to a patient. He does not assume responsibility for services or acts of independent non-physicians who independently provide services related to health conditions

within the sphere of activities for which licensed.

Allied personnel licensed by the state to provide independent services must function within their licensure, and must refer to a physician for medical services.

#### **D. Delegation of Duties**

Physicians may delegate to non-physicians (allied health personnel) those tasks which are delegable, for which the person performing such tasks is appropriately qualified and trained, and within the scope of licensure, if any, of such allied health person.

When delegated, tasks must be performed under the direction and supervision of the physician, and the physician must remain responsible.

No delegated task will abrogate a physician's responsibility nor should it abet the illegal practice of medicine or allow non-authorized independent practice of medicine by non-physician professionals.

#### **E. Joint practice**

In many institutional settings, physicians and allied health professionals share in provision of personal services, within the scope of individual education and licensure. Each professional contributes different skills and abilities to the care of patients. In this context, certain activities should be established:

- (1) Develop written criteria and policies for determining the role and responsibility of the doctor and the allied health professional in performing certain patient care procedures;
- (2) Devise methods to implement and communicate decisions regarding areas of dependent functions;
- (3) Review at stated intervals any significant changes and developments in medical and allied health profession practice.
- (4) Establish mechanisms for continuing review of the quality of care provided by personnel within the scope of criteria and policies establishing a joint practice relationship.

#### **F. Protocols/Standing Orders**

In the delegation of duties and to pro-

vide appropriate response in specific situations or circumstances, a physician may devise mechanisms to allow certain functions to be accomplished by allied health personnel prior to physician evaluation and prescription or to meet emergency situations when the physician is not present. These must be limited, must be reviewed periodically, and should not absolve a physician from responsibility in patient care.

#### **INTERRELATIONSHIPS**

Various interrelationships exist—those in which the physician employs an allied health professional as well as those in which an allied health professional is employed by an institution or agency and the physician is responsible for direction of such personnel.

Allied health professionals shall not accomplish those acts properly performed by physicians without appropriate physician direction and supervision.

- (1) Allied health professionals may not, independent of physician direction, diagnose illness or prescribe drugs or therapy. Responsibility for patient care rests with a physician.
- (2) A nurse or other allied health professional may not independently undertake any invasive procedure.
- (3) Registered or licensed allied health personnel may practice only within the scope of activity for which they are registered or licensed.
- (4) An allied health professional may not independently refer a patient for medical care to anyone other than one licensed to render such care.

Since many viewpoints are in existence as to the role various categories of health care professionals play, as well as expansion on roles through modification of licensure laws, the medical profession must meet with groups representing allied health professionals to come to terms in these matters, emphasizing that the physician is responsible for diagnosis and prescription while others appropriately provide ancillary services.

Regardless of the type of relationship, the physician should be prepared to establish a diagnosis for the condition being treated. The physician also should satisfy himself that the competence of any non-physician health care provider providing services to the physician's patient is sufficient to provide the treatment indicated and delivered. The physician should be able to provide periodic



evaluation of the patient's condition through personal examination so that revision, continuation or termination, as indicated, of the patient's treatment plan may be approved. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment or skill or which tend to cause a deterioration of the quality of health care. When a physician assumes a supervisory or collaborative role with a non-physician health care provider, the physician should expend sufficient time to assure that proper health care is given. It is contrary to the interest of the patient for the physician to allow himself to be only nominally involved in patient care.

Allied health personnel shall function only under the direction of a physician licensed to practice medicine in all its branches, which physician is responsible for the differential diagnosis, prescription of therapeutic or corrective measures, and delegation of appropriate tasks, and allied personnel shall perform only those acts in the provision of health care services specifically allowed by appropriate licensure or registration acts.

Whenever professional services are provided by non-physician personnel, and such services could

be provided by a physician, then the non-physician person must go through a similar credentialing process to that of the physician, and evaluation and monitoring must be under the same process.

#### IV. SUMMARY

In the health care field there is a growing number of individuals who provide health care services. It is essential that the qualifications of these individuals, the delineation of services they provide, and the review of their activities be accomplished by physicians, as physicians practice medicine and are directly responsible for patient care, diagnosis and prescription. It is the function of medicine to recommend the scope of activities of allied health professionals, recognizing education, experience and licensure of such personnel.

Through development of this position statement, definitional differentiation and relationships are addressed to assist in establishing a model within which various concerns regarding allied health personnel can be considered.

ISMS Task Force on New Health Practitioners  
April 23, 1980 and June 11, 1980  
Amended and adopted, Board of Trustees  
June 28, 1980

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# Resolution of Influenzal Pneumonia

BY GEORGE S. DEEPE, JR., M.D. AND LANIE E. EAGLETON, M.D./SPRINGFIELD

*The clinical course of a previously healthy 32-year-old man with primary influenza pneumonia is described. Because severe hypoxemia developed, mechanical ventilation, positive end expiratory pressure, and corticosteroids were employed in his management. The residual interstitial pulmonary disease in our patient was mild relative to that of previously reported cases managed with mechanical ventilation. We postulate that adjunctive therapy such as positive end expiratory pressure and corticosteroids may be beneficial in preventing the pulmonary complications of primary influenza pneumonia.*

Influenza is a major cause of death and morbidity. Pulmonary fibrosis, bronchiolitis obliterans and bronchiectasis are among the sequelae.<sup>1</sup> Improvements in health care including antibiotics, oxygen, and mechanical ventilators have decreased the mortality rate. Although a recent report suggests that one may expect significant pulmonary dysfunction,<sup>2</sup> there is still a paucity of information regarding the prognosis for individuals who survive by virtue of mechanical ventilation. There is even less information to guide therapy designed to prevent the sequelae in such patients. We report a patient with severe influenzal pneumonia, treated with assisted ventilation, oxygenation, positive end expiratory pressure (PEEP) and steroids, who survived with only mild abnormalities in pulmonary function.

## Case Report

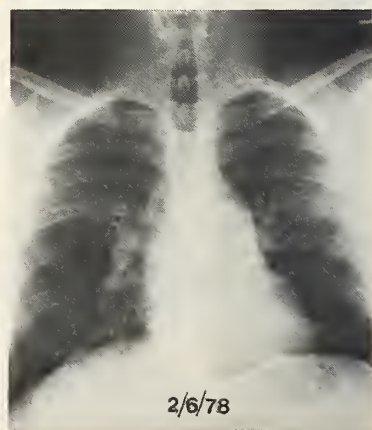
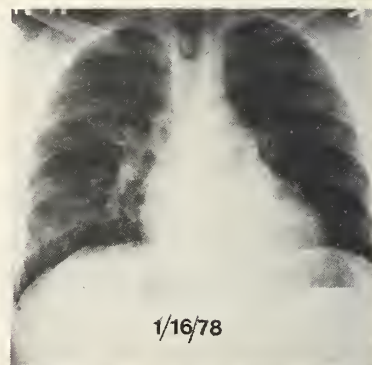
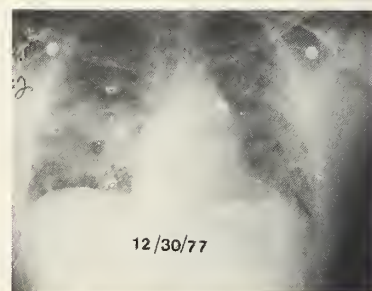
This previously healthy 32-year-old man developed chills, myalgias, fever and non-productive cough on December 26, 1977 during an Influenza A<sub>2</sub> epidemic in Central Illinois. He was admitted three days later because of respiratory insufficiency. His past medical history

was unremarkable. He was employed as a utility man in a meat-processing plant.

At the time of admission he had a respiratory rate of 35/min., pulse of 78/min. and a blood pressure of 140/70. Inspiratory rales and expiratory wheezes were noted. No opening snap or mitral rumble was heard. The remainder of the examination was normal. Laboratory data included: hemoglobin-14.1 g/dl; hematocrit-41%; WBC count was 9,200/cu mm with 37% bands, 55% segs, 1% lymphocytes, 3% monocytes; arterial blood gases on oxygen 15 liters/min. by non-rebreather masks: pH-7.43, pCO<sub>2</sub>-32.7 torr, pO<sub>2</sub>-60.5 torr; LDH-3520 IU, SGOT-60 IU, SGPT-41 IU, normal bilirubin, ESR-41mm/hr (Wintrobe); cold agglutinins and monospot were negative. His electrocardiogram was normal. A gram stain of the sputum showed moderate polymorphonuclear leukocytes, few gram negative diplococci, few gram positive cocci in pairs, chains, and clusters, and few small gram negative bacilli. Chest X-ray (Figure 1a) showed diffuse alveolar and interstitial infiltrates.

Because of progressive respiratory insufficiency with a P<sub>a</sub>O<sub>2</sub> of

**Figure 1**  
Demonstrates the resolution of the diffuse pulmonary infiltrates



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**Table 1**

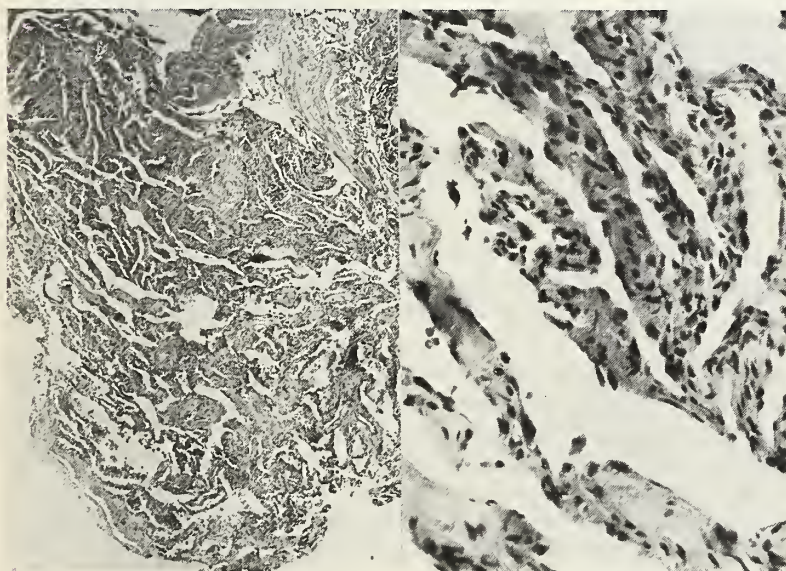
PULMONARY FUNCTION

		11/17/78	2/6/78	3/6/78
Test	Predicted	ACTUAL (% Predicted)*	ACTUAL (% Predicted)*	ACTUAL (% Predicted)*
Total Lung Capacity	6.73 Liters	5.33 (79%)	5.93 (88%)	6.45 (96%)
Vital Capacity	5.11 Liters	3.58 (70%)	4.30 (84%)	4.56 (89%)
FEV <sub>1</sub>	4.15 Liters/mm.	3.30 (80%)	3.83 (92.7%)	3.87 (94%)
MMEF	4.32 Liters/mm.	7.97 (184%)	5.32 (123.%)	5.26 (122%)
Single Breath CO diffusion	34 (ml/min/mm.Hg.**)	18 (53%)	21 (62%)	23 (68%)
SaO <sub>2</sub> rest		90%	94%	94%
SaO <sub>2</sub> exercise		89%	94%	93%

Table 1: Table 1 shows pulmonary function studies determined on 22nd, 42nd, and 60th day of the illness which are compatible with slow resolution of mild restrictive defect.

\* % Predicted based on values of Kary normals.<sup>9</sup>

\*\* CO diffusion based on data of Burrows et al.<sup>10</sup>



**Figure 2**

**Hypercellularity and fibrosis of alveolar wall under light microscopy.**

40 torr on 15 liters by non-re-breather mask, he was intubated on the second hospital day and supported with assisted volume ventilation with an initial F<sub>I</sub>O<sub>2</sub> of 70% and PEEP of 10cm. He was started on Solu-Medrol (R) 80mg. IV twice a day following a one gram bolus and on two grams Keflin (R) IV every four hours. His P<sub>a</sub>O<sub>2</sub>

on the ventilator ranged from 72 torr to 112 torr. His PEEP was maintained for 10 days after intubation and he was extubated on the 12th hospital day. Steroids were continued as 80mg. a day and were decreased to 30mg. a day on the twentieth hospital day.

Three weeks after admission he had persistent rales and wheezes,

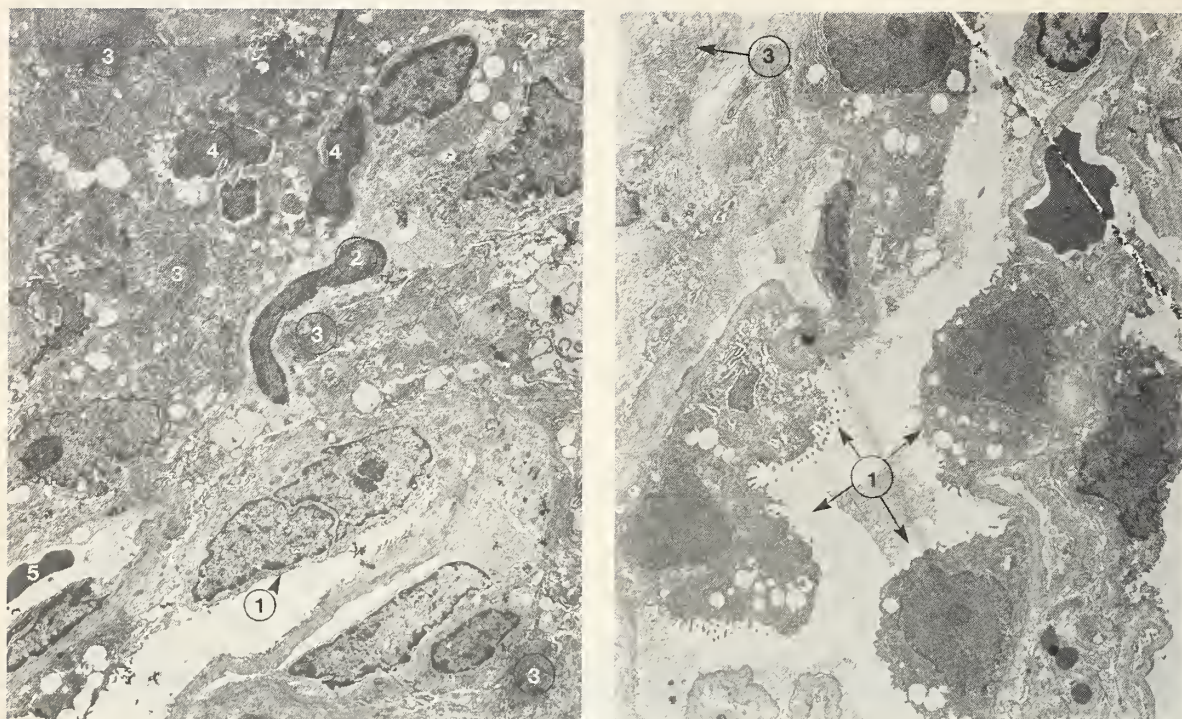
alveolar and interstitial infiltrates on chest X-ray, (Figure 1b) and mild restrictive disease by pulmonary function testing (Table 1). On the 22nd hospital day, transbronchial biopsies were taken from the right lower lobe with a resultant pneumothorax which required thoracostomy tube drainage. The vocal cords were ulcerated and the airways were hyperemic at the time of bronchoscopy. Interstitial pulmonary fibrosis was present on all four biopsy specimens (Figure 2). He was discharged on the 25th hospital day on Prednisone 40 mg. every other day.

The patient returned for follow-up the 42nd and 60th day since the onset of his illness. He reported improving exercise tolerance. The rales and wheezes were less extensive; the abnormalities in pulmonary functions and chest X-ray (Figure 1c) had improved. Acute and convalescent titers for Influenza A<sub>2</sub> by complement fixation were 1:16 to 1:512 respectively. No virus, fungi or bacteria grew from lung biopsy tissue, and no viral inclusions were seen on electron microscopy (Figure 3).

#### Discussion

Primary influenza pneumonia as an entity distinct from concomitant bacterial pneumonia was described





**Figure 3**

**Electron micrographs of lung biopsy**

**(1) Proliferation of Type II pneumocytes lining alveolar wall; (2) Fibroblast; (3) Collagen deposition; (4) Polymorphonuclear leukocyte; (5) Red blood cells in alveolar capillaries.**

and was recognized as a cause of death prior to identification of the influenza virus.<sup>3</sup> Early death from the adult respiratory distress syndrome—alveolar damage with hemorrhage, transudation, and hyaline membranes—is a constant feature of fatal primary influenza pneumonia.<sup>3-5</sup> Louria, *et al.*, pointed out the ineffectiveness of antibiotics, steroids and oxygen in preventing death from severe influenza pneumonia. Five of their six patients died from the acute illness.<sup>5</sup> Although their patients had coexistent cardiac disease and ours did not, we believe our patient survived because of current availability of assisted ventilation.

Winterbauer, *et al.*, utilized assisted ventilation for 11 patients with influenza pneumonia.<sup>2</sup> Five of these survived. However, all five had significant lung dysfunction

which were attributed to pulmonary fibrosis when studied one year later. Our patient, however, who had experienced an acute disease of comparable severity, as judged by hypoxemia and pulmonary infiltrates, had less residual abnormality of lung mechanics and gas exchange. This difference could be related to the utilization of PEEP and steroids.

Douglas, *et al.*, have suggested that PEEP may lessen the residual impairment following the Adult Respiratory Distress Syndrome.<sup>6</sup> Stoler and Davis suggested steroids improved the survival rate in patients mechanically ventilated for influenza pneumonia.<sup>7</sup> Bogart reported a patient who was analogous to ours managed with PEEP and steroids and who survive with "essentially normal" pulmonary function. These authors have not re-

ported a trial of Amantadine.<sup>8</sup> However, Amantadine has been tried in less severe disease and shown to accelerate the improvement in pulmonary physiologic abnormalities.<sup>9</sup> Although there is little precedent, we believe Amantadine, steroids and PEEP may be useful in an effort to prevent the sequelae of influenza pneumonia in those patients who require assisted ventilation. However, we must caution all physicians against the employment of steroids until controlled studies have substantiated their safety and efficacy in influenza pneumonia. ◀

**References**

A complete list of references may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.



# Abstracts of Board Actions

(continued from page 56)

- Co-sponsor with IDPH a six-month study on cervical cancer to determine what modes of early diagnosis are most effective, relative cost of each, and which women stand in greatest need of efforts in early diagnosis. The study would examine cases of cervical cancer found over the past 15 years in the medical practices of a majority of doctors serving a self-contained relatively stable population of 60,000-100,000 persons. The plan for the study would be developed with the full participation of practicing physicians in the community, and a local nurse—retained with the authorization of the local medical society—would review patient records for the retrospective 15 years on a confidential basis. ISMS will work with IDPH to develop a format for the study.
- Co-sponsor with the American Society of Law & Medicine an Oct. 16-17 conference in Chicago on "Legal and Ethical Aspects of Treatment of The Terminally Ill."
- Conduct a seminar on the role of allied health professionals, October 23, in Peoria. The Illinois Hospital Association will be asked to participate in the program

## ILL. GUARDIANSHIP & ADVOCACY COMMISSION

ISMS will assist the Ill. Guardianship & Advocacy Commission (IGAC) in securing medical consultants to advise the IGAC staff when a question arises over granting of consent for a medical procedure involving an incompetent ward of the State. IGAC will appoint at least one medical consultant in each downstate IDMHDD region. Ideally, physicians—preferably involved in primary care—would be located near IGAC satellite offices in Elgin, Rockford, Peoria, Springfield, Harrisburg, Champaign and E. St. Louis. ISMS trustees in those areas will identify physicians willing to serve as medical consultants. Under the arrangement, referrals to specialists will be authorized when needed and patient visits may be involved.

## ALLIED HEALTH PERSONNEL

The Board adopted a position paper, titled "Physician Interrelationships with Allied Health Personnel," which: (1) Defines categories of allied personnel; (2) Sets guidelines for physician/allied personnel relationships, focusing upon lines of authority and responsibility; and (3) Defines physician responsibility for insuring that allied personnel do not exceed the scope of their licenses. The position paper is published in this issue of the *Illinois Medical Journal*.

In related action, the Board reaffirmed its support of a statement on "Joint Practice" adopted in 1976 by ISMS and the Illinois Nurses Association. However, the Board deleted this peripheral quotation: "Joint practice is nurses and physicians collaborating as colleagues to provide patient care."

## BLOOD BANKING

To implement a House of Delegates directive, ISMS last year developed a Statewide Blood Banking Coordinating Committee under the Society's Laboratory Services Committee. The goal of the Blood Banking Committee—composed of representatives from ISMS and the state's 20 blood banks—is to coordinate activities of the blood banks and thereby solve blood shortage and distribution problems.

The Chicago Regional Blood Program (CRBP) plans to cease operations and is prepared to issue a grant to an organization that would work toward increasing blood donations, improving blood safety and availability, and improving operation of blood centers. ISMS, through its Educational and Scientific Foundation, will seek a \$250,000 CRBP grant to support activities developed by the ISMS-sponsored Statewide Blood Banking Coordinating Committee. Periodic reports of Coordinating Committee activities will be forwarded to county society presidents.

## 1981 HOUSE, BOARD MEETING DATES

The following dates and locations were selected for the 1981 Board of Trustees and House of Delegates meetings:

### *House of Delegates*

Apr. 5-8	Radisson Chicago Hotel, Chicago
Nov. 6-8	Springfield Hilton, Springfield

### *Board of Trustees*

Jan. 24-25	Palmer House, Chicago
Apr. 4-8	Radisson Chicago Hotel, Chicago
June 27-28	Marriott O'Hare, Chicago
Sept. 19-20	Hyatt Regency O'Hare or Marriott O'Hare, Chicago
Nov. 6-8	Springfield Hilton, Springfield

## MALPRACTICE LEGISLATION

Last April, the ISMS House of Delegates expressed opposition to the broadened application of the "res ipsa loquitur" doctrine as a method of proving medical negligence under guidelines and edict of the Illinois Supreme Court. At the direction of the House, legal counsel reviewed the Supreme Court decision of *Spidel vs. Steward* and concluded that—since the Supreme Court has refused to reconsider its decision—a legislative change in the law is the only avenue available to remedy the consequences of this decision. Acting upon legal counsel's recommendations, the Board:

- Authorized ISMS to retain the services of Atty. Rich Record, Mattoon, to assist in drafting legislation.
- Directed the Ad Hoc Committee to Study the Backlog of Professional Liability Cases—which includes a cadre of defense lawyers—to assist in finalizing the proposal for Board approval and introduction in the General Assembly next January.

## HOUSE OF DELEGATES RESOLUTIONS

At its annual meeting, the House of Delegates referred several resolutions to the Board for study and report back. Acting on those proposals, the Board voted to recommend that the House:

- Adopt—in lieu of Res. 80A-19—a substitute resolution that would set the following policy on "Autonomy of County Medical Societies":  
"In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform, where not inconsistent with law, to the Principles of Medical Ethics of the American Medical Association and the Constitution and Bylaws of the Illinois State Medical Society."
- Reject Res. 79N-13 which called on the Board to "dissolve ICCME within three months and assign its duties to appropriate regular councils and committees . . . and the AMA-ERF again receive the full \$20 per donating member which it formerly received from ISMS." In relation to this action, the Board directed the Planning & Priorities Committee to study the ISMS-ICCME relationship and appropriate methods of funding ICCME. The Committee will present its recommendations at the next Board meeting.
- Adopt Res. 80A-35—establishing a revised policy statement on "Multiphasic Screening"—with the following amendment (*italic*):  
"Multiphasic screening (including brief physical examination and multiple automated laboratory tests), are accepted procedures for health evaluation when carried out in a scientific manner *and in conformance with laws of the State of Illinois and regulations of the Department of Public Health*. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities."



- Adopt Sub. Res. 80A-1 which directs ISMS to "support the concept that Illinois medical students, whose medical education is supported by Illinois tax money, be encouraged to remain in Illinois to practice." The Board also called for exploration of ways to encourage retention of physicians in Illinois.

## ADDITIONS TO POLICY MANUAL

In accordance with House of Delegates' action, the Board approved the following policy statements for inclusion in the Policy Manual:

### *Fund Solicitation by Persons Affiliated with HSAs*

"The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practice may affect the objectivity of the organization."

### *Physician's Assistants*

"The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician."

### *Hospital Medical Staff Privileges*

"Members of a medical staff should receive due process as spelled out by the bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society supports physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients."

### *Resident Participation at County Level*

"The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level."

The substance of Res. 80A-8—Public Health Department Activities—was combined with an amended version of the existing policy statement on "Public Health Departments" so that the Policy Manual would state:

### *Public Health Departments*

"Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts including contributions by voluntary health associations, medical societies, and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

*ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.*

*ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: (1) Coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; (2) The availability of private medical services; (3) The gaps in medical and health services that should be filled by public health activities; and (4) The socio-economic characteristics of the population to be served."*

## IDPA DRUG MANUAL

The following drugs were approved for inclusion in the IDPA Drug Manual: Nucofed (Syrup and Capsules), Cerubidine, Halciderm, Naldecon DX Syrup, and Naldecon EX Pediatric Drops. ISMS will urge IDPA to add a new general classification to the Manual covering drugs needed to treat conditions commonly affecting Southeast Asian refugees. The classification would be titled: "Drugs for Parasitic Infections Not Otherwise Listed—If Law Requires RX."

## FINANCIAL AID SURVEY

County medical societies will be polled to determine sources of financial aid for medical students available through local communities. The poll is part of on-going activities to implement a House directive that ISMS support and investigate low cost loans for medical students.

## SPORTS MEDICINE

ISMS will urge the Illinois State Board of Education to establish a Sports Medicine Office and ask the General Assembly's leadership to urge its development. The Governor's Task Force on Athletic Injuries has called for creation of the Office which would be responsible for matters pertaining to the health and well-being of interscholastic athletes in Illinois . . . and Gov. Thompson has endorsed the proposal.

In related action, the Board adopted a position statement which acknowledges that athletic trainers provide a valuable service in monitoring athletic injuries, and urges the Illinois Office of Education to establish minimal qualifications for athletic trainers who serve on the staffs of Illinois schools.

## APPOINTMENTS/NOMINATIONS

Several hundred ISMS members were appointed to one-year terms on the Society's various councils and committees for 1980-81. Appointed Council chairmen were: Drs. *Theodore Grevas*, Rock Island, Economics; *Donald Pochly*, North Chicago, Education & Manpower; *Howard Burkhead*, Evanston, Governmental Affairs; *Donald Aaronson*, Chicago, Medical-Legal; *Joseph Winterhalter*, Jacksonville, Medical Service; *Arthur Traugott*, Urbana, Mental Health & Addiction; *Peter Vinciguerra*, Libertyville, Public Relations & Membership Services; and *Gustav Giebelhausen*, Peoria, Affiliate Societies.

The following physicians were nominated for appointment to State bodies:

- *Dr. Willard Scrivner*, Belleville—reappointment to Department of Registration & Education's Medical Disciplinary Board.
- *Dr. John Froiland*, Chicago—Board for Opinions on Professional Nursing.
- *Dr. Mack Hollowell*, Charleston—IDPH Medical Determination Board.
- *Dr. Robert Reeder*, St. Charles—reappointment to Illinois Hospital Licensing Board.

Appointed ISMS representatives to State bodies were:

- *Dr. Sam Andelman*, Skokie—Technical Advisory Group to the Illinois Health Facilities Planning Board's Task Force on State Health Facility Planning.
- *Dr. Frank Jirka, Jr.*, Barrington—Technical Advisory Committee of the Illinois Health Finance Authority.

Acting on behalf of ISMS—the sole shareholder in Illinois State Medical Insurance Services, Inc. (ISMIS)—the Board authorized its chairman to cast the Society's vote to re-elect the following physicians to the ISMIS Board of Directors; Drs. *Warren Tuttle*, Harrisburg; *Alfred Clementi*, Arlington Heights; *Robert Hamilton*, Chicago; *J.M. Ingalls*, Paris; *Clifton Reeder*, Park Ridge; *Phillip Boren*, Carmi; and Mr. *Roger White*, ISMS executive administrator. These individuals will be elected to the Board at the annual meeting of ISMIS shareholders July 2. ◀



## *First New County In Over 50 Years*

# Marshall-Putnam Counties Form New Component Society

At their February, 1980, meeting, the ISMS Board of Trustees was pleased to grant a charter to the newly formed Marshall-Putnam Medical Society—the first new county society to join ISMS in over 50 years.

Organized by Joe Cannon, M.D., president and Merle Swearingen, M.D., both of Lacon, Marshall-Putnam will now join the component societies of the Second District. They will be represented on the Board of Trustees by Allan L. Goslin, M.D., trustee for the Second District.

Unsuccessful efforts to form a county society date to at least 1921. The minutes of the 1921 House of Delegates report may be of interest:

“Dr. E. E. Perisho, Streator, reported for the Second District as follows:

“Ten different counties are represented in the Second District and we have seven of these in good working order, well organized and holding two meetings a year. A few of the larger counties have subdivisions. The two counties not in good working order are Marshall and Putnam. They have been on the ragged edge for years because of mud roads, small towns, and only two or three men in each town, with no place to meet. I have made a personal visit to every physician in the two counties, trying to persuade them to keep up their organization in a better way. I was unable to find a single man in the two counties who wanted to keep up the organization. Their plea is that they are so situated with mud roads, small towns, and no place to meet. Some of them find it easier to take the train to Peoria and attend meetings there, and the men to the south and east can go to the towns near them which are accessible by train. We have given some of these men the privilege of joining the other county



(L-R) Joe Cannon, M.D., Lacon, president, Merle Swearingen, M.D., Lacon, ISMS delegate and Don Gallagher, M.D., Granville, secretary of the newly formed Marshall Putnam Medical Society, receive their charter from the ISMS Board of Trustees.

societies.”

Members of the Marshall-Putnam Medical Society inquired about organizational criteria in May, 1979. A Constitution and Bylaws were submitted. The ISMS Board of Trustees voted to charter the new society at their February 19, 1980, meeting. That charter was formally presented at the April, 1980, meeting of the ISMS House.

# Pulse of the ISMS Auxiliary

## A Winning Team ISMSA BOARD OF DIRECTORS

BY MRS. HARLAN FAILOR, PRESIDENT

The leaders of the Illinois State Medical Society Auxiliary are its officers, its district councilors, and the chairmen of its standing and special committees—compositely speaking, its Board of Directors—and from this Director's viewpoint, we've got a winning team!

According to one definition *a leader is someone going somewhere, who is able to persuade others to go with him*. But forty leaders all headed in different directions could never give guidance to an organization, or even gain its respect. For a Board to succeed, every member must view her own job in relation to the work of the whole, and all members must consider the questions of financing, programming, public relations, and management as a team. Your present Board of Directors does these things superbly, and thus provides outstanding leadership.

But this year's Board does more than fulfill its leadership responsibilities. There is a little parody that says:

"And though I have the gift of organization, and understand all mysteries of the group process;

And though I have all faith in my ability to accomplish, and have not spirit . . . I am nothing.

And now abideth business-like methods, social processes, spirit, these three;  
But the greatest of these is *spirit!*"

This element of spirit—morale—*esprit de corps* . . . from where does it come? It comes from a belief in the organization. A belief in its purpose, its goals, and its ideals. If an individual Board member should lack this belief, then she must look inside herself. But if the entire Board should ever lack this belief, then we must look inside the organization—and change it.

To meet with this Board is to discover and experience this spirit. And when you add spirit to leadership, you've got a *winning team!*



(LEFT TO RIGHT) *First Row:* Mrs. Irvin Blumfield, 3rd vice-pres.; Mrs. Robert Webb, secretary; Mrs. R.S. Hoover, director; Mrs. Harlan Failor, president; Mrs. Harold Keegan, president-elect; Mrs. Gamil Arida, second vice president; Mrs. Julian Buser, treasurer. *Second Row:* Mrs. Earl Klaren, members-at-large; Mrs. Eugene Leonard, director; Mrs. Grover Seitzinger, 8th district councilor; Mrs. Morris Friedell, editorial; Mrs. Reuben Gaines, former finance chairman; Mrs. Selig Hodes, AMA-ERF; Mrs. Louis Tarsinos, 2nd district councilor; Mrs. Ashvin Patel, archives; Mrs. M.W. Hollowell, humanitarian award; Mrs. Francis Graff, parliamentarian and Mrs. Alex Spadoni, public relations. *Third Row:* Mrs. Wayne Kassel, health maintenance; Mrs. Karl Reddies, AMA-ERF; Mrs. John Simonaitis, 11th district councilor; Mrs. Robert Hartman, bylaws; Mrs. Paul Stanley, fall conference; Mrs. John McLean, 4th district councilor; Mrs. George Olander, cult awareness; Mrs. E.W. Lowry, 1st district councilor and Mrs. Robert Kooiker, 6th district councilor.

**ISMSA BOARD MEMBERS NOT PICTURED ABOVE:** Mrs. Donald Hinderliter, 1st vice president; Mrs. James Gwaltney, director; Mrs. W.J. Olszewski, 3rd district councilor; Mrs. Robert Reardon, 5th district councilor; Mrs. Jerry Beguelin, 7th district councilor; Mrs. Gerald Fox, 9th district councilor; Mrs. Paul Norbet, 10th district councilor; Mrs. John Leonard, 12th district councilor; Mrs. Robert L. Rockey, AMA-ERF; Mrs. August Martinucci, benevolence; Mrs. Fred Nathan, community health; Mrs. Jack Hull, convention; Mrs. Frank A. Lippi, convention; Mrs. Jack Brodsky, family health; Mrs. William Hodges, finance; Mrs. Donald DePinto, health education-health careers; Mrs. Alan Taylor, legislation; Mrs. Edward Szewczyk, spouses of physicians in training; Mrs. William Simon, hospitality and Mrs. Jane Swanson, executive secretary.



# Viewbox

(Continued from page 59)

## Diagnosis: (2) Lipoid Pneumonia

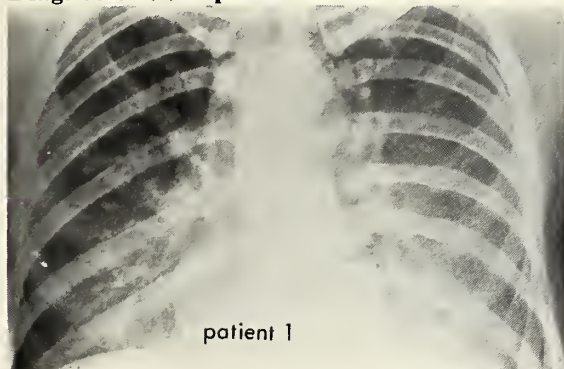


Figure 3

Patient 1. (10 years before Figure 1). Early lipid pneumonia with uniform alveolar consolidation of the lower lobes.

The diagnosis of lipid pneumonia is often unexpectedly made by the pathologist following open lung biopsy. A patient with a single mass is usually considered to have a bronchogenic carcinoma while diffuse lung changes may be mistaken for bronchiolar carcinoma, tuberculosis, fungal disease, or idiopathic pulmonary fibrosis. The rare case of pseudolymphoma or its diffuse counterpart, lymphocytic interstitial pneumonia, may also mimic lipid pneumonia.<sup>1</sup>

Most cases of lipid pneumonia are the result of long term use of mineral oil or, less commonly, oily nose drops. The patients seldom mention these substances when asked a general question concerning medications. When asked specifically about these over the counter medications, usually in retrospect, they reveal the positive history crucial to the interpretation of their radiographic abnormalities.

The majority of patients are asymptomatic but they may have dyspnea, wheezing, cough, or hemoptysis. Cases of severe *cor pulmonale* have been reported. An occasional patient has intermittent episodes of low grade fever with or without documented infection. Rarely, a patient presents with a subacute febrile illness after using mineral oil for a few weeks.<sup>2</sup>

Vegetable fat, animal fat, and mineral oil are the principle types of lipid which may be aspirated. Vegetable fat causes little tissue reaction and is promptly expectorated. Animal fat is hydrolyzed to fatty acids in the lung and the liberated fatty acids cause severe inflammation, necrosis, and fibrosis. Mineral oil is the most common cause of lipid pneumonia. Mineral oil does

not stimulate the cough reflex and also interferes with ciliary action. If taken at bedtime, mineral oil is commonly aspirated in small amounts. This oil causes little inflammatory response in the lung. It is emulsified in the alveoli and then phagocytized. Macrophages then return to the lung interstitium. The macrophages die releasing lysosomes and proteases with eventual fibrosis and granuloma formation resulting in parenchymal scarring and pools of free oil. Oil is also picked up by lymphatics and draining lymph nodes. Other reported sources of exogenous oil causing lipid pneumonia include: nose drops, throat sprays, gargles, Mandelamine suspension, Chap Stick, Vicks, burning fat, atomized oil sprays used in industry, and milk or oil aspiration in infants. Elderly patients and patients with esophageal problems (stenosis, diverticulum, and motility disturbance) are at increased risk.

If the diagnosis is suspected, sputum samples should be obtained. 5-50  $\mu$ m fat staining vacuoles within macrophages are reliable evidence of exogenous oil aspiration. Not all patients with lipid pneumonia have positive sputum, however. Finely dispersed intracellular oil is not specific and may be seen in several inflammatory conditions of the lung.<sup>2</sup> Lung biopsy is diagnostic. Gas-liquid chromatography is needed to specifically identify fat as being mineral oil in sputum or tissue.<sup>3</sup>

Radiographic findings are most common in the lower lobes, especially the right lower lobe. As with other forms of aspiration, the location of pathology depends on the patient's posture so that even the upper lobes may be involved when the patient aspirates oil in the supine position. Early radiographic changes are characterized by alveolar consolidation primarily due to oil in the alveoli (Figure 3).<sup>4</sup> Most patients present with conglomerate masses, dense fibrosis, or a single mass. Each of these represent late pulmonary findings. These lung changes slowly progress if oil use is continued. If oil use is discontinued the lung changes may remain stable or slowly regress. A few symptomatic patients have improved following steroid therapy. ◀

## References

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3. Heckers, H., Melcher, F., et al: "Paraffin Oil Pneumonia," *J. Chromatog.* 146:91, 1978.
4. Weill, H., Ferrons, V. J., et al: "Early Lipoid Pneumonia," *Am. J. Med.* 36:370, 1964.
5. Genereux, G.: "Lipids in the Lungs: Radiologic-Pathologic Correlation," *J. Can. Assoc. Rad.*, 21:2, 1970.

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**8th Weber Medical Clinic**  
For: MD's. Symposium, Oct. 25, Olney. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Breast Cancer & Other Problems in Hematology/Oncology**  
For: MD's. Symposium, Oct. 30, 2:00 p.m., Lincoln. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Fee: \$25. Reg. limit: none. Credit: Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**The Limping Child**  
For: MD's. Symposium, Oct. 31, Springfield. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Office Dermatology**  
For: MD's. Symposium, Oct. 30, 7:00 p.m., Ina. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Respiratory Tract Infections**  
For: MD's. Symposium, Oct. 29, 1:00 p.m., Marion. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Grief Counseling: A Conference for the Caring Professionals**  
For: MD's. Symposium, Oct. 15, 6:00 p.m., Alton. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Gynecologic Pathology**  
For: MD's. Symposium, Oct. 8, Springfield. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Emotional Problems in Office Practice: Origins & Treatment**  
For: MD's. Symposium, Oct. 3. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*Hypnosis*

**Workshop on Clinical Hypnosis**  
For: MD's. Workshop, Oct. 16-19, Chicago. Sponsor: American Society of Clinical Hypnosis—Education and Research Foundation, 2400 E. Devon Ave., Suite 218, Des Plaines 60018. Reg. deadline: none. Fee: \$295. Reg. limit: none. Credit: Category 1, 25 hours; AAFP Elective, 25 hours; APA Continuing Education Registry, 25 hours. Contact: William Hoffman, Jr. Phone: 312/297-3317.

*Pediatrics*

**Introduction to Sports Medicine Through Adolescence**  
For: MD's. Symposium, Oct. 11, Aurora. Sponsor: Copley Memorial Hospital, Lincoln and Weston Aves., Aurora 60507. Cosponsor: Mercy Center for Health Care Services. Reg. deadline: 10/6. Fee: none. Reg. limit: 60. Credit: Category 1, 6 hours. Contact: Julius Newman, MD. Phone: 312/897-6021.

*Primary Care*

**Clinical Management of Coronary Disease and Exercise Testing**  
For: GP's, Internists. Lectures/workshops, Oct. 31-Nov. 2, Chicago. Sponsor: International Medical Education Corp., 64 Inverness Dr. E., Englewood, CO 80112. Reg. deadline: none. Fee: \$245, MD; \$130, technician. Reg. limit: 60. Credit: Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. Contact: Stephen Mattingly. Phone: 800/525-8646 x 237.

*Private Medical Practice*

**Choosing and Using a Computer in Private Medical Practice**  
For: MD's. Lecture, Oct. 31-Nov. 1, Chicago Marriott O'Hare Hotel. Sponsor: University of Health Sciences/Chicago Medical School, 2020 W. Ogden Ave. Chicago 60612. Attn: Dr. Bush. Reg. deadline: 10/10. Fee: \$260. Reg. limit: 100. Credit: Category 1, 15 hours. Contact: Ben Blivaiss. Phone: 312/942-2965.

*Contemporary Topics in Psychiatry*

For: Psychiatrists. Lecture, Oct. 6-10, Chicago. Speaker: Domeena Renshaw, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$325. Reg. limit: 125. Credit: Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

*Surgery*

**Specialty Review in General Surgery, Part I**

For: General and Specializing Surgeons. Lecture, Oct. 6-17, Chicago. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$550. Reg. limit: 400. Credit: Category 1, 94 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

*Ultrasound*

**First Annual St. Louis University Ultrasound Symposium**

For: MD's, ultrasound sonographers. Symposium, Oct. 23-25, St. Louis, MO. Sponsor: Dept. of Radiology, School of Medicine, St. Louis University, 1402 S. Grand, St. Louis, MO 63104. Reg. deadline: 10/16. Fee: \$250, MD; \$150, sonographer. Reg. limit: none. Credit: Category 1, 16-18 hours. Contact: John Grellner. Phone: 314/664-9800 x 127.

**NOVEMBER**

*Arthritis*

**Rehabilitation of the Patient with Arthritis**

For: MD's. Course, Nov. 20-22, Chicago. Sponsor: Rehabilitation Institute of Chicago, 345 E. Superior, Chicago 60611. Cosponsor: American Academy of Physical Medicine and Rehabilitation. Fee: \$150, MD; \$90, resident. Credit: Category 1, 21 hours. Contact: Don Olson. Phone: 312/649-6179.

*Cardiovascular Emergencies*

**Cardiovascular Emergencies, Part II**

For: MD's. Symposium, Nov. 5, 8:00 a.m., Waukegan. Sponsor: Victory Memorial Hospital, 1324 N. Sheridan Rd., Waukegan 60085. Fee: \$5, Victory staff, \$10, others. Reg. limit: 110. Credit: Category 1, 5 hours; AAFP Elective, 5 hours. Contact: S. R. Veiga, MD. Phone: 312/688-4253.

*General Medicine*

**Recent Advances in Diagnosis and Management of Cardiac Arrhythmias**

For: MD's. Course, Nov. 12, Brookfield, WI. Sponsor: The Medical College of Wisconsin, 8701 Watertown Plank Rd., Milwaukee, WI 53226. Fee: yes. Reg. limit: none. Contact: Willard Duff.

*General Medicine*

**Exercise and the Heart—Post-Myocardial Infarction**

For: MD's. Symposium, Nov. 6, 1:00 p.m., Hillsboro. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Pediatric Problems**

For: MD's. Symposium, Nov. 6, 1:00 p.m., Pittsfield. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Diabetes, Diagnosis and Management**

For: MD's. Symposium, Nov. 13, 9:00 a.m., East St. Louis. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$25. Credit: Category 1, 3 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Renal Dysfunction**

For: MD's. Symposium, Nov. 20, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Reg. limit: none. Fee: \$30. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Medicine*

**Obstetrics and Gynecology: Art and Science**

For: Obstetricians, Gynecologists. Caribbean Cruise/Course, Nov. 29-Dec. 10. Sponsor: SIU School of Medicine, CME, 801 N. Rutledge, Springfield 62708. Fee: yes. Credit: Category 1, 55 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

*General Practice*

**Transfusion Reactions**

For: MD's, RN's, MT's. Lecture, Nov. 20, Davenport, Iowa. Speaker: Richard Walker, MD. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust St., Davenport, Iowa 52803. Fee: \$15, MD; \$4, others. Reg. limit: 200. Credit: Category 1, 2 hours; AAFP Prescribed, 2 hours; AOA, 2 hours; Board of Nursing and PACE, 0.2 CEU. Contact: Patricia Harrod. Phone: 319/359-5401.

**Aging and Illness in Primary Care**

For: MD's. Lecture, Nov. 5-7, Madison, WI. Sponsor: CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. Fee: \$215. Credit: Category 1, 21 hours; AAFP. Contact: Sarah Aslakson. Phone: 608/263-2850.

*Psychiatry*

**Transference in Psychoanalytic Psychotherapy**

For: Psychiatrists, Psychologists. Course, Nov. 1-2, Sheraton Plaza Hotel, Chicago. Sponsor: The Chicago Institute for Psychoanalysis, 180 N. Michigan Ave., Chicago 60601. Fee: \$150. Reg. limit: none. Credit: Category 1, 10 hours. Contact: Richard Telington, MD. Phone: 312/332-2448.

*Pulmonary*

**Pediatric Pulmonary Conference**

For: MD's. Course, Nov. 19, Chicago. Sponsor: Chicago Lung Association, 1440 W. Washington, Chicago 60607. Course Director: Dharmapuri Vidyasagar, MD. Phone: 312/243-2000.

*Respiratory*

**Respiratory Care Conference**

For: MD's. Lecture, 4th Tuesday of month, 8:30 a.m., Melrose Park. Sponsor: Westlake Community Hospital, 1225 Superior St., Melrose Park 60160. Fee: none. Reg. limit: none. Credit: Category 1, 1 hour. Contact: Frank Sedlak, MD. Phone: 312/681-3000 x 210.

*Respiratory*

**Acute Respiratory Failure—Admission to Discharge**

For: MD's. Workshops, Nov. 6-8, The Inn on the Park, Madison, WI. Sponsor: CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. Fee: \$150, MD; \$100, RN, resident. Credit: Category 1, 15 hours; 1.5, CEU. Contact: Sarah Aslakson. Phone: 608/263-2850.

*Surgery*

**Workshop on the Use of Stethoscope in Surgery**

For: Surgeons. Workshop, Nov. 14, 8:00 a.m., St. Louis, MO. Sponsor: Dept. of Surgery, St. Louis University Medical Center, 1402 S. Grand Blvd., St. Louis, MO 63104. Cosponsor: Autostures, Inc. Fee: \$200. Reg. deadline: 11/7. Reg. limit: 10. Credit: Category 1, 7 hours. Contact: John Grellner. Phone: 314/664-9800 x 127.

*Trauma*

**Symposium on Trauma**

For: MD's. Symposium, Nov. 7, 14 and 21, 11:15 a.m., Oak Park. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Reg. limit: none. Credit: Category 1, 3 hours. Contact: Charles Weigel, MD. Phone: 312/366-7870.

**CME Planning Aids**

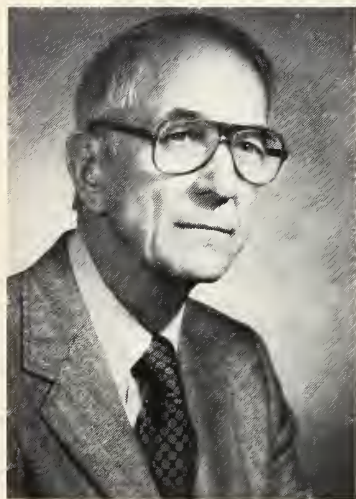
"The Illinois Handbooks on CME Planning" are nationally recognized as the best available. Sold to all interested at cost of preparation and shipping, they're available to ISMS members at a 50% discount.

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# President's Page



## *An Idea For The 80's*

### THE CHALLENGE FOR GERONTOLOGY— THE GRAYING OF AMERICA

One of every nine Americans is over age 65. In times past, old age was a treasured distinction. Today, the term "aging" frequently is considered a mingling of negative factors involving income, isolation and health.

Every day we deal with the health problems of the aged. What is our goal? Near perfect health is unrealistic . . . a fact acknowledged—but not accepted—by "oldsters." They seek medical care to maintain or improve their limited physical abilities.

Too often our advice restricts freedom, diminishes pleasure and fosters dependency. We give aged patients the "Hobson's choice" of less pleasure or a longer life.

Not too long ago, a physician taking a patient's history and asking why a relative died would be told "he died naturally." In this age of advanced technology, nobody dies "naturally."

In 1900, the average male lifespan was 42. Today, male life expectancy is 74. The ability of the aged to withstand the onslaught of physiological, cultural and social attacks is miraculous. Retirement dictates a lifestyle of unstructured time and reduced interaction with the community. Meanwhile, society places a premium on being young, and technology adds to the quantity of life at the expense of quality.

The staff of the White House Conference on Aging—scheduled for November, 1981—is urging state and local medical societies to initiate community forums that will address the problems of aging. It's worth considering. ◀

*Herschel Browns MD*

Herschel Browns, M.D., President ◀



# Doctor's News

**PHYSICIAN RECRUITMENT UPDATE**—Two major physician recruitment efforts are scheduled for this fall. ISMS will co-sponsor the second annual Physician's Practice Opportunity Job Fair, held by the SIU Medical School on September 10, in Springfield. The ISMS eighth annual Doctors Job Fair in Chicago will be held September 28, 1980. For further information about the latter event, please contact the ISMS offices.

**DIVISION OF ALCOHOLISM, IDMHDD** has renewed their grant to ISMS for education of physicians in treatment of alcoholism. The grant, which supports the ISMS Scientific Speakers Bureau Alcoholism Education Roster, also provides for the annual State Fair Booth display in alcoholism education and, this year, will aid in efforts to assist the Jail Health Program in pertinent activities.

**INSURANCE UPDATE**—Reports indicate some members attempting to renew coverage under the ISMS-sponsored Hospital Indemnity Plan—underwritten by The Hartford—mistakenly have enrolled in a program called "Illinois Physicians Benefit Fund."

Corroon & Black of Illinois, Inc. (C&B) recently assumed administration of all Society-sponsored insurance plans in a move designed to eliminate administrative fragmentation & permit overall upgrading of the programs. After securing a 10% increase in cash benefits for Indemnity Plan participants, C&B mailed billings for the July 19 coverage renewal. But Robinson Administrative Services—the program's former administrator—used the policyholder list to solicit enrollment in the Benefit Fund which is not endorsed by ISMS. *Members who erroneously paid the Benefit Fund bill may request coverage cancellation & a premium refund by contacting Robinson Administrative Services, 209 S. LaSalle St., Chicago 60604.*

In a related development, the ISMS Board of Trustees has shifted ISMS sponsorship to a new life insurance program underwritten by North American Co. for Health & Life Ins. Details of the plan—which offers a \$1 million maximum benefit—& enrollment information will be forwarded to all members by C&B. Physicians covered under the current life insurance program may renew their policies on an individual basis through A.W. Ormiston & Co. . . . & those with "insurability" problems particularly are encouraged to do so. Questions concerning any ISMS-sponsored insurance program should be directed to: Terri Townsend, administrator, ISMS Insurance Plans, Corroon & Black of Ill., Inc., 135 S. LaSalle St., Chicago 60603, (312)-621-4909. When available, materials will be mailed to all ISMS members.

**DRUG MANUAL UPDATE**—IDPA has reversed its position on "less than effective" drugs and will reimburse for this category of drugs per their notification to practitioners dated June 25. (Notification includes the drug list originally deleted from the July 1 drug manual.)

The FDA interim classification does not represent a final determination and the list includes many drugs that have been judged by the FDA to be medically necessary, that exhibit proven effectiveness for certain indications and/or that may be subsequently upgraded to "effective." The IDPA regulation contravened the policy of DHHS and HCFA, which is to permit reimbursement for drugs classified as "ineffective" until a final determination of efficacy has been made.

To repeat, the so-called "ineffective" or "less than effective" drugs dropped from the July 1 printing of the IDPA drug manual *will* be reimbursed until further notice.

**PHYSICIANS IN THE NEWS**—**Jack Gibbs, M.D.**, Canton, has been elected to serve on the AMA Council on Medical Education. **John J. Ring, M.D.**, Mundelein, was re-elected to his post on the AMA Council on Medical Service . . . which later acted to elect him vice-chairman.

Several ISMS students and residents were also elected to national posts at the recent AMA annual meeting. **L. Ann Nunnally, M.D.**, Chicago, was elected to serve on the AMA Council on Medical Education . . . Dr. Nunnally is the ISMS Resident Physician Section delegate to the AMA-RPS. **David Olive, M.D.**, was elected secretary of the AMA/RPS Governing Council . . . Dr. Olive is the ISMS-RPS delegate to the ISMS House. **Ron Davis**, ISMS Student Business Section delegate to the ISMS House, was elected to the AMA-SBS Governing Council.

The AMA Board of Trustees has appointed **George Bruce Thow, M.D.**, Urbana, to an additional term on the American Board of Colon and Rectal Surgery.

The ISMS Board of Trustees appointed the following chairmen of Society councils and committees for 1980-81: **Drs. Theodore Grevas**, Rock Island, Economics; **Donald Pochyly**, N. Chicago, Education & Manpower; **Howard Burkhead**, Evanston, Governmental Affairs; **Donald Aaronson**, Chicago, Medical-Legal; **Joseph Winterhalter**, Jacksonville, Medical Service; **Arthur Traugott**, Urbana, Mental Health & Addiction; **Peter Vinciguerra**, Libertyville, Public Relations & Membership Services; & **Gustav Giebelhausen**, Peoria, Affiliate Societies.

Re-elected to the Ill. State Medical Insurance Services, Inc., Board of Directors were: **Drs. Warren Tuttle**, Harrisburg; **Alfred Clementi**, Arlington Heights; **Robert Hamilton**, Chicago; **J.M. Ingalls**, Paris; **Clifton Reeder**, Park Ridge; **Phillip Boren**, Carmi; & **Mr. Roger White**, ISMS executive administrator.

**Cyril C. Wiggishoff, M.D.**, has been inaugurated as president of the Chicago Medical Society. Dr. Wiggishoff, former speaker of the ISMS House of Delegates, is a member of the ISMS Board of Trustees. Concurrently, **Robert C. Hamilton, M.D.**, Chicago, was installed as president-elect; **Alfred J. Clementi, M.D.**, Palatine began a second term as CMS secretary and **John P. Harrod, Jr., M.D.**, Chicago, was re-named treasurer. **Harold J. Lasky, M.D.**, Evanston, will serve as the CMS Council chairman and **Harry A. Springer, M.D.**, Evanston, as vice chairman.

**Robert D. Hart, M.D.**, Peoria, has been inaugurated as president of the Illinois Chapter, American Academy of Pediatrics . . . ICAAP also acted to name **Eugene F. Diamond, M.D.**, Chicago, "Pediatrician of the Year," an award given annually in memory of Dr. Albert Pisani. . . **Robert G. Thompson, M.D.**, Chicago, has been named chief of staff for Northwestern Memorial Hospital in Chicago.

**IMPAIRED PHYSICIAN CONFERENCE ANNOUNCED**—"Threshold '80: Building Well-Being," is the title of the AMA's fourth national conference on the impaired physician, scheduled for Wednesday, October 29 through Saturday, November 1, in Baltimore, Maryland. Hour-for-hour category 1 CME credit will be available to participants, and registration cost is \$60 for AMA members. Further information may be obtained through the AMA Department of Meeting Services, 535 N. Dearborn St., Chicago IL 60610; (312) 751-6503. Registration is limited.

**CORRECTION**—We have learned that an error occurred in publication of "Successful Hyperalimentation in a Community Hospital," which appeared on pages 223-225 of the April issue (Volume 157, No. 4, 1980). That article made reference to "intra-lipid". We have since been informed that **INTRALIPID®** is a registered trademark for which Cutter Laboratories, Inc., of Emeryville, CA is sole licensee. **INTRALIPID®** is registered for fat emulsion for intravenous use, and the term may not be used generically. References to that product should refer to "INTRALIPID® 10% I.V. fat emulsion." We apologize.



# IMPAC

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE**

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1886-1975

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The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# Classified Advertising

All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of \$2 will be assessed when a box number is requested.

## CLASSIFIED ADVERTISING RATES

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	\$6.00	\$9.00	\$14.00	\$20.00
3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

## POSITIONS & PRACTICE OPPORTUNITIES

**WANTED:** Family Practitioner to join well-established physician who is planning to retire in the next four years. Complete clinic facilities and full hospital privileges. Guaranteed salary and opportunity for early partnership and possible sale of practice in the near future. Pana is a rural community of 6,000 with a modern hospital which has excellent services and equipment. Contact: H. W. Hess M.D., 213 S. Locust St., Pana, Illinois 62557 or call Hospital Administrator Don Ciulla (217) 562-2131.

**THE OPPORTUNITY** to supplement your income by providing part-time coverage in emergency departments statewide. As the largest provider of ED management and staffing in the state, we can schedule coverage according to your needs. Competitive compensation plus paid professional liability insurance. For details, send credentials to Spectrum Emergency Care, Inc., Department 101PT 970 Executive Parkway, St. Louis, MO 63141, or call toll-free 1-800-325-3982 and ask for part-time scheduling.

**EMERGENCY MEDICINE OPPORTUNITY** in the southern portion of the state. Evening and weekend coverage available in this low-volume ED. Competitive compensation, flexible scheduling, and paid professional liability insurance. For details, send credentials to Frank Siano, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free, 1-800-325-3982.

**DIRECTOR OF EMERGENCY SERVICES**—Opportunity available July 1 for a qualified physician to assume the directorship of a modern emergency department. This midwestern university community provides cultural and recreational activities for every member of the family. Earn an excellent income while enjoying the freedom from "on-call" responsibilities. Malpractice insurance provided. For further details, submit credentials in confidence to Frank Siano, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free, 1-800-325-3982.

**EMERGENCY MEDICINE OPPORTUNITIES** available—Clinical and directorship positions available throughout the state. Excellent income while enjoying the freedom of flexible scheduling and no "on-call" responsibilities. Professional liability insurance in the amount of \$5,000,000.00 is provided. For details, submit credentials in confidence to Rena Ballard, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free, 1-800-325-3982.

**FAMILY PRACTITIONER**—To locate in Nashville, Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263, 618 327-8236.

**FAMILY PRACTICE** available August 1, 1980 in fully-equipped established office. Retiring. \$10,000 investment financed. New building. Great location for family in central Illinois. Phone number 309-723-4671.

**INTERNISTS**—Excellent practice opportunities in a thriving rural community. Enjoy life and your practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. We have weekend Emergency Room coverage. Join the active Medical Staff of a growing 112-bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury, IL 61739.

**PEDIATRICIANS**—Excellent practice opportunities in a thriving rural community. Enjoy life and your practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. We have weekend Emergency Room coverage. Join the active Medical Staff of a growing 112-bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury, IL 61739.

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**OB/GYN PHYSICIANS**—Excellent practice opportunities in a thriving rural community. Enjoy life and your practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. We have weekend Emergency Room coverage. Join the active Medical Staff of a growing 112-bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury, IL 61739.

**INDIANA**—Fort Wayne—emergency physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc., 4400 Broadway, Suite 306, Kansas City, Missouri 64111, (816) 931-3040.

**MESA** has openings for qualified emergency physicians in a northwest area close to Chicago. Excellent community setting and new progressive hospital make a perfect opportunity for a physician and his family. MESA offers salary computed up to \$84,000 annually, flexible scheduling and excellent fringe benefits. Send your C.V. or telephone: MEDICAL EMERGENCY SERVICE ASSOCIATES (MESA), S.C., 188 Industrial Drive, Suite 316, Elmhurst, Illinois 60126; Ms. Barten (312) 832-4504.

**ORTHOPEDIC SURGEON**—Board Certified or Board Eligible Part Time for a new rapidly expanding independent medical evaluation practice. Two locations, north suburban and south side of Chicago. Please send resume and CV to Box 970, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603. Note: All of our personnel know of this ad.

**EMERGENCY MEDICINE OPPORTUNITY** in central portion of the State. Clinical position available; two 24-hour shifts per week. Attractive financial package, liability insurance provided. For details, send credentials in confidence to Frank Siano, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free, 1-800-325-3982.



**DIRECTOR OF EMERGENCY SERVICES**—directorship position available in this modern emergency department located in a central Illinois university community. Excellent income, liability insurance provided, other amenities. For details, send credentials to Frank Siano, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free 1-800-325-3982.

**MODERN EMERGENCY DEPARTMENT** seeking director and staff physicians. This southern Illinois location offers the cultural and educational advantages of a large university setting. Moderate volume, excellent income, paid malpractice. For details, send credentials to Paul Mulder, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free 1-800-325-3982.

**WESTERN INDIANA:** Clinical and directorship opportunities available in this moderate volume trauma center. The metropolitan location provides cultural, educational, and recreational facilities for all members of the family. Excellent minimum guarantee plus production bonus. For details, send credentials in confidence to Mr. Joseph Woddail, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free 1-800-325-3982.

**MIDWEST COMMUNITY** 100 miles from Chicago needs 2 additional family practitioners to join multi-specialty group of 12 physicians; guaranteed income; clinic directly across from hospital; excellent fringe benefits; Profit-Sharing Plan. Contact Box #971 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**INTERNIST NEEDED** to join 4 internists in multi-specialty group of 12 physicians; in progressive midwest community 100 miles southwest of Chicago; full partnership after one year; excellent fringe benefits. Contact Box #972, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**WANTED—PHYSICIAN, INTERNAL MEDICINE** (General), Fulltime Permanent, at Veterans Administration Medical Center, Marion, IL. Beginning salary up to \$50,112 per year depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any state. Potential for clinical associate professor with affiliating school of medicine. Contact Chief of Staff, VA Medical Center, Marion, IL 62959, telephone (618) 997-5311. An Equal Opportunity Employer.

**ANESTHESIOLOGIST WANTED** to join the Central Wisconsin Anesthesiology, S.C., which consists of three established, hospital based anesthesiologists. All specialties are served including open heart, neuro, obstetrics & gynecology. If interested phone (715) 845-5505 or write to: Central Wisconsin Anesthesiology, S.C. 425 Pine Ridge Blvd. Suite 207 Wausau, WI 54401.

**DIRECTOR:** Illinois State University Health Service. Medical degree and Illinois license OR at least master's degree from a health care and/or hospital administration program. Administrative and clinical responsibilities for staff of six physicians, 13 RNs and various support staff for university of 19,000 residential students. Salary competitive; starting date open. Send resume and support materials to: Dr. Douglas Lamb, Health Service Search, Student Counseling Center, Illinois State University, Normal, Illinois 61761. Search will continue until a suitable pool of candidates is found. Illinois State is an equal opportunity/affirmative action university.

**EMERGENCY MEDICINE OPPORTUNITIES** available in North Central Illinois: Directorship and clinical positions available. 30,000 + annual patient visits. Excellent compensation plus fringes. For more information, contact Mr. Frank Siano, 970 Executive Parkway, St. Louis, MO 63141, or call toll-free, 1-800-325-3982.

**PSYCHIATRIST OR INTERNIST** to work with three physicians (two psychiatrists and a neurologist) and a multidisciplinary staff in a substance misuse program (inpatient and outpatient). Training in alcohol and drug misuse preferable, but program can provide training. Salary and faculty rank in Department of Psychiatry and Behavioral Sciences, Medical School, Northwestern University, dependent upon qualifications. Needed as soon as possible. Equal opportunity employer. Send curriculum vitae to Lee Gladstone, M.D., Institute of Psychiatry, Northwestern Memorial Hospital, 320 E. Huron St., Chicago, IL. 60611.

**TIRED** of the traffic Doctor, tired of spending two hours a day in your car going to the hospital and office? We need a GP or Family Practice man in a beautiful city of 10,000 in western Iowa, rich farming community, 5 minutes from almost new 100 bed hospital with good lab, x ray pathology and radiologist on staff. Many beautiful homes, new recreation center with pool, country club. Good contract, Good Guarantee, well established group since 1928. Please write or call Ed Murphy, Clinic Manager, Carroll Medical Center, 502 N Court St., Carroll, Iowa 51401.

**PHYSICIAN:** Full time (40 hours per week) board certified internist, board eligible cardiology, salary \$45,445 per annum plus standard hospital fringe benefits package. Duties: to be associate to the Director of Department of Cardiology, patient care and teaching in this long-term care facility. Must have Illinois State License. Contact JACK SOBEL, MD, FACP, Medical Director. (312) 928-4200 Oak Forest Hospital, Oak Forest, ILL 60452. An Equal Opportunity Employer.

**EMERGENCY DEPARTMENT POSITIONS,** available in North Central Illinois as well as other desirable areas. Contact Jan or Rod, Emergency Consultants, Inc., 2240 S. Airport Rd., Traverse City, Mich. 49684 or call 1-800-253-1795, In Michigan 1-800-632-3496.

**WANTED!—** Full time board certified anesthesiologist as assistant department head. Rapidly expanding 300 bed hospital on Chicago's south side with nine new ultra modern equipped operating rooms. Some supervisory and some teaching experience required. Submit curriculum vitae and references to: BOX 974, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

## SITUATIONS WANTED

**OB-GYN—BOARD ELIGIBLE**—seeks solo practice or association with either ob-gyn, or family practice physician. Write to Box #962 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**DERMATOLOGIST**, thirty-three years old, training recently completed, with flexible schedule desires part time (20-30 hours/week) association with clinic, health maintenance organization, or practicing dermatologist in Chicago metropolitan area. James M. O'Dowd, M.D., 307 Buckthorn Lane, Hillside, Ill. 60162.

## FOR SALE, LEASE OR RENT

**PRIME INVESTMENT**, prime location, fronting beautiful, lush green scenic golf course. 10, 20, 30, 40 acres of gently rolling land, \$5,000 per acre and DOWN if large parcel purchased. Worthy of your investigation. Kindly call IREC, Inc. Melanie Everett, 649-6662.

**LARGE MEDICAL CENTER:** corner masonry building, 18 years old with 13 medical and dental practitioners. Gross income \$31,000. Doctor leaving for California and is anxious to sell. Please call Melanie Everett, IREC, Inc. 649-6662.

**FOR RENT—SUBURBAN—DELUXE OFFICE SPACE:** For lease within medical/dental complex. Ideal location in far northwest Cook County. Close to new 315 bed hospital. Over 12,000 square feet of fully equipped, modern suites now available with pharmacy, X-ray, and laboratory facilities. Large waiting area, receptionist, parking. Call 830-1900.

**MEDICAL OFFICE SUITE FOR RENT**, Lincoln-Belmont Bldg., Chicago, Ill. 900 sq. ft. available immediately in full service, elevator professional building. Call Gary Solomon, 334-5400.

**MEDICAL CONDOS.** Close to Good Samaritan and Hinsdale Hospitals, 63rd & Cass; Westmont. John H. Doyle, Real Estate. (312) 231-9582.

**BARRINGTON:** Deluxe 800 sq. ft. suites available for any specialty. All independent. Ample parking. Few Min. from Good Shepherd and Suburban Hospital. Reasonable terms. 312-381-5800 or 381-4160.

**FOUR BEDROOM** beautifully furnished bayfront house for rent in Holmes Beach—Sarasota, Florida area. Available Oct, Nov, Dec, Jan, Feb, Mar. of this coming year. No children or pets allowed. \$500.00 a week. References needed. Contact S. A. Zaharokis, M.D. (312) 728-2677.

**MEDICAL BUILDING—**Prime Franklin Park Location, housing 4 Doctors, medical lab & drug store. Owner will consider contract purchase \$340,000 (A28) 745-1717

**ELMWOOD PARK MEDICAL BUILDING/Office Complex.** Convenient adjacent parking lots. \$1,000,000 (50) 386-3083.

**FOR RENT—**4 room suite in active medical building 450 square feet plus common waiting room. Utilities and parking furnished. Excellent southwest suburban location on main thoroughfare. Suitable for family practice, internist, G.P. general surgery, dermatologist. Available August 1st, 1980. Phone 661-6290 or 388-8247.

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# Continuing Education

Every physician enjoys the opportunity to leave the press of daily practice for a CME course out of town—and every day's mail brings a seeming flood of brochures announcing these courses. The latter fact raises a crucial question: "How can I make wise choices among all the available CME courses?" This checklist can prove helpful:

1. *Do not throw away all those brochures and announcements.* Ask your office nurse or secretary to save them; once every two or three weeks, review the collected pile—and then throw away the ones that don't interest you.

2. *Do take a close look at your own needs and concerns.* Here's a procedure many practitioners find useful: Ask your office nurse or secretary (or your hospital records room) to tabulate the kind of patient problems you've confronted in recent weeks or months. As you review the list, consider (a) on which kinds of problems you feel you could improve your performance through some additional learning, and then (b) any objective evidence—e.g., recent audit or UR report from your hospital—that suggests you're not performing up to your own standards. Use this data to focus on specific learnable things—new information (or review of important areas like joint injuries, low back pain or immunology), or improved skills, or deeper understanding of the kind of patient problems you confront. THEN:

3. *Review those brochures in terms of your self-analysis.* Look especially for these features: (a) Does the brochure announce goals and/or objectives? (b) Does it describe the learning procedures to be offered? If the brochure doesn't tell you—throw it away. If it does—decide whether the described learning procedure will help solve your learning problems. (c) Will the program offer you opportunity to assess how much you learned?

If you're satisfied on these three points, the program announced by that brochure is probably worth the time and money you'll spend attending the course. If you're not satisfied—look further.

## Doing it Systematically

Several thousand physicians systematize this procedure using *Your Personal Learning Plan, A Handbook for Physicians*. Copies are available at \$2.00 for ISMS members and \$4.00 for non-members. For your copy, write or call: Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603 (telephone, 312/236-6110).

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**Indications**—Symptomatic relief of anxiety and tension associated with anxiety disorders, other psychoneurotic disorders, transient situational disturbances, and functional or organic disorders. Symptomatic relief of acute alcohol withdrawal.

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**Warnings**—Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 18. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**Precautions**—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**Adverse reactions**—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

**Dosage**—ANXIETY—Usual daily dose 30 mg or less (start the elderly or debilitated at 7.5-15 mg). Adjust gradually within 15-60 mg daily range. Capsules and scored tablets: divided doses; or once daily h.s. (start patient at 15 mg). Single Dose Tablets, 22.5 mg (for patients stabilized on 7.5 mg t.i.d.) or 11.25 mg, once daily at any hour. ALCOHOL WITHDRAWAL—In divided doses: 1st day 30 mg initially, then 30-60 mg, 2nd day 45-90 mg; 3rd day 22.5-45 mg, 4th day 15-30 mg. Then taper to 15-7.5 mg daily, and discontinue as soon as stable.

**Interactions**—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants.

**Overdosage**—Take general measures as for any CNS depressant.

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0033338

# EKG

(Continued from page 57)

Answers: 1. C 2. E

The Holter monitor ECG recording shows sinus rhythm with somewhat progressive ST segment elevation. There are baseline artifacts related to the patient's movements while taking a sublingual nitroglycerin tablet. This was effective in relieving the angina and the ST segment returned to the baseline. In addition, the sinus rate fell from 100/minute to approximately 72/minute. No cardiac arrhythmias were ever recorded in this patient. Prinzmetal's variant angina was initially described as a rest angina associated with ST segment elevation. Often the patients had normal exercise capacity. More recently, ST elevation has been described in these patients in exercise as well as rest (*Circulation* 59:580 and 948, 1979). All of the statements in question two are true. Our patient underwent a second coronary arteriogram which showed much progression in his coronary artery disease. He had a successful double aorta coronary bypass and has done well thus far. Aorta coronary bypass surgery in some of these patients has had mixed results and must be carefully considered. Two months after his surgery, our patient was able to perform a normal Bruce protocol exercise ECG for a total of eleven minutes and ten seconds without pain.

# "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

September 14	Memorial Hospital of Elmhurst & A.C.S.	Elmhurst
September 15	Christ Hospital	Oak Lawn
October 6	Lake Forest Hospital & A.C.S.	Lake Forest
October 13	St. Mary's Hospital	Quincy
October 28	Lutheran General Hospital & A.C.S.	Park Ridge
November 17	Christ Hospital & A.C.S.	Oak Lawn
December 1	Anchor & A.C.S.	Chicago

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# REPORT

## FOR *Illinois Physicians*

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### Coordination of Benefits

#### Coordination of Benefits — a System to Conserve Health Care Dollars

We need your help in obtaining the information to make Coordination of Benefits work.

When a person is covered by more than one group health care insurance policy it is beneficial to both the patient and the insurance carriers to share financial responsibility for payment of the insured person's health care claim. This shared financial responsibility between health insurance carriers is called Coordination of Benefits or COB.

In many families both wife and husband are employed and often both are covered by family contracts on two different health care programs. When a husband or wife need medical attention, it is possible to collect a claim against both health insurance programs. However, health insurance is not intended to pay in excess of the cost of actual illness.

Such duplication of benefits drives up health insurance rates and needlessly pays beyond the cost of the health care provided.

To do our part to keep health care costs down we ask that you complete the section on the Blue Cross and Blue Shield's Physician's Service Report which asks,

"Does the patient have any other group insurance?" If so, we also request that you obtain the name and location of the other insurance company.

It is also very important for you to let us know if the husband or wife is also covered in another group by Blue Cross and Blue Shield. It occurs when one spouse is enrolled in one employer's group and the other spouse is enrolled in another employer's group. Help us make Coordination of Benefits work by filling out that section on the Blue Cross and Blue Shield's Physician's Service Report, then leave the rest to us.

We will determine the extent of liability of the Commercial insurance company or the Blue Cross and Blue Shield Plan involved in the Coordination of Benefits Program. By providing as much information as you can and by completing the section on Coordination of Benefits it will help to reduce unnecessary health care expenditures, help prevent unnecessary claim delays, and will strengthen the voluntary effort in cost effective claims administration.

## Concurrent Medical Care

When a patient is admitted to the hospital primarily for surgical or obstetrical care, additional benefits for concurrent medical care rendered by a physician other than the surgeon or obstetrician would be paid under most Blue Shield certificates provided: (1) there are *unusual circumstances* and (2) *specialized medical care . . . is essential to and distinct from the surgical or obstetrical care*. Allowances vary according to the type of Blue Shield certificate held by the member.

Some examples of eligible claims for concurrent medical care are as follows:

(1) The patient is admitted as a medical patient and treated medically for a period before being transferred to the surgical or obstetrical service. In such cases, the physician rendering medical care should bill Blue Shield for his services to the date of transfer;

(2) The patient is primarily a medical patient, and the surgery performed is a minor procedure or diagnostic in nature. In these cases, the physician

rendering medical care should bill Blue Shield for the entire period of hospitalization;

(3) The patient develops a post-operative condition requiring specialized medical services. In these cases, the physician rendering medical care should bill Blue Shield from the date he enters the case to the date of completion of his hospital service;

(4) The patient has a medical condition requiring close supervision both pre and post-operatively. In this case, the physician should bill Blue Shield for the entire period of hospitalization and describe in detail the condition of the patient.

Admission date, discharge date, diagnosis and the number of in-hospital daily visits made must be reported before claims can be paid. To avoid returning reports for additional information which delays payments, the question on the Blue Shield's Physician's Service Report must be completed, e.g., "Was surgery also performed," and "If so, by whom?" even if all services performed were medical.

In most Blue Shield certificates payment for in-hospital medical care is limited to one visit per day.

---

## Payment for Surgical Assistance and Consultations

Some Blue Shield certificates provide benefits for the services of surgical assistants. A number of major accounts including the Steel and Motor group, Federal Employees Program, Bell Systems and Jewel Companies have included this benefit in their contracts and will pay for the services of a surgical assistant, provided:

(1) The hospital does not employ surgical interns, residents or house staff who are utilized for such assistance, and

(2) The operation is major enough to require an assistant surgeon.

In each case the assistant surgeon should submit his own Physician's Service Report form and describe fully the assistance he gave the operating

surgeon. His report should include the operating procedure performed and the name of the operating surgeon. Benefits are determined by the type of contract held by the member.

### Consultations

Some Blue Shield contracts provide benefits for the services of a consultant when requested by the attending physician. The amount of payment is based on the Blue Shield certificate in force.

Allowances are provided for one consultation per admission in a hospital or extended care facility. Consultations are not in benefit for radiology, pathology or when payment has been made to the same physician for surgical service or obstetrical care.

The consulting physician must submit his own Service Report and include the name of the attending physician who requested the consultation.





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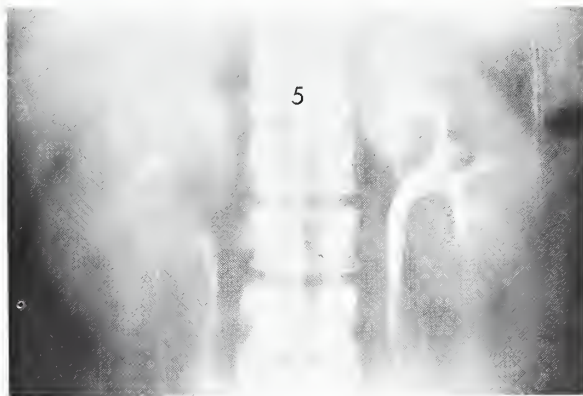
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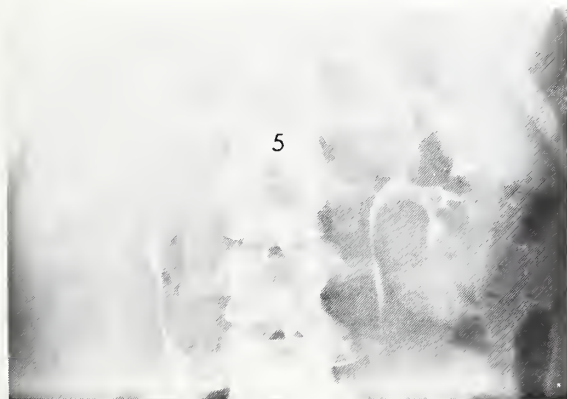
# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*Patient 1 is a 20 year old hypertensive black woman who has had "stabbing" right upper quadrant pain for one day. Patient 2 is a 22 year old white woman who had had right flank pain for three days. Both patients have low grade fever and abnormal urinalysis. They have the same diagnosis.*



**Figure 1—Patient 1:** Nephrotomogram (Left) One minute film with abnormal (faint) right nephrogram. (Right) At five minutes there is filling of a right upper pole calyx but no filling of lower pole calyces.



**Figure 2—Patient 2:** Intravenous urogram (Above) Five minute film. The right kidney is enlarged and calyces thinned. (Right) Ten minute film. The entire length of the right ureter is slightly dilated.



## ***Your diagnosis?***

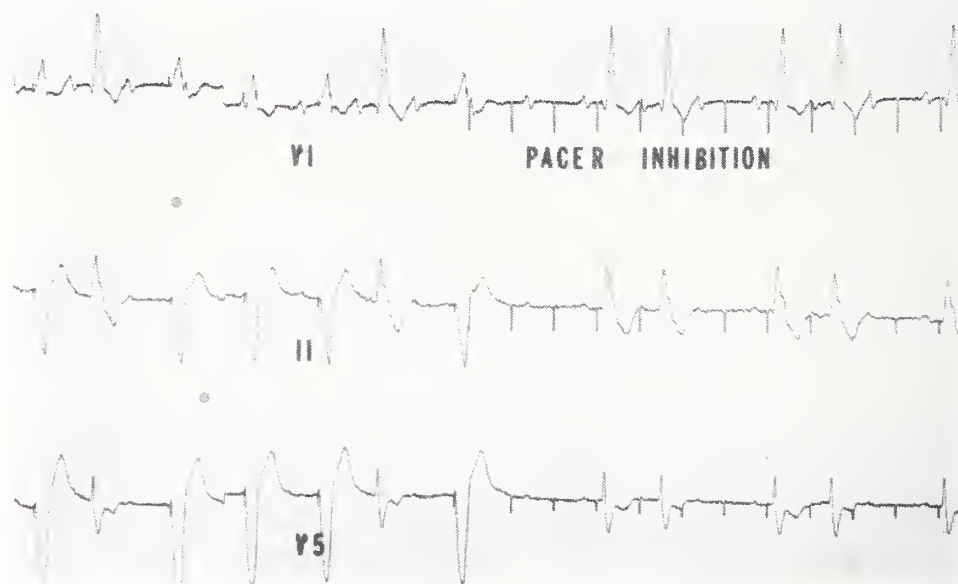
1. Acute pyelonephritis
2. Renal vein occlusion
3. Ureteral obstruction
4. Renal artery occlusion
5. Renal lymphoma

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# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tabin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This is a seventy-five year old patient with a long history of coronary artery disease. He has suffered two myocardial infarctions and congestive heart failure. Five years ago he developed heart block and a permanent demand pacemaker was placed in the right ventricle by the transvenous route. This had been replaced because of battery failure two months ago. In the past two weeks, he complained of two episodes of near-syncope. He had recovered from both episodes without permanent injury. Physical examination demonstrated a faint ventricular gallop with an irregular cardiac rhythm. A repeat MUGA ejection fraction by nuclear medicine was unchanged at 20% and a chest X-ray showed cardiomegaly. A simultaneous leads  $V_1$ , II, and  $V_5$  rhythm strip was performed with pacemaker inhibition.*



## Questions:

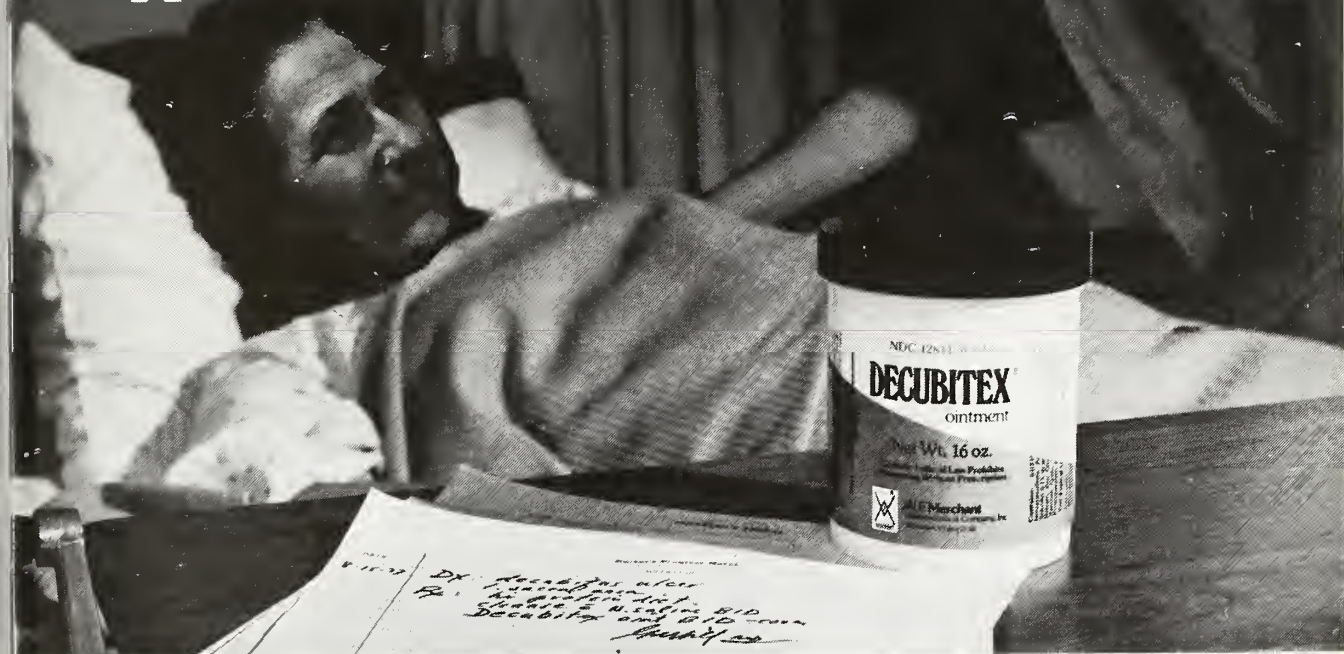
1. The ECG rhythm strip show(s):
  - A. A well-functioning demand pacemaker.
  - B. Sinus capture beats.
  - C. An electrical artifact at a rate of 120/minute that interferes with pacemaker function.
  - D. An underlying sinus rhythm with 3:2 atrio-ventricular block and complete right bundle branch block.
  - E. All of the above.
2. Pacemaker threshold is the minimal electrical energy that will stimulate the heart. Some of the factors which tend to increase the pacing threshold are:
  - A. Sleep or rest.
  - B. Eating.
  - C. Electrolyte imbalance, especially hyperkalemia.
  - D. Drugs such as procainamide or quinidine.
  - E. All of the above.

(Continued on page 158)



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# Pulse of the ISMS Auxiliary

## You Can't Get Better Than First

BY MRS. HARLAN FAILOR, ISMSA PRESIDENT

It all began with a letter from Mrs. Quentin L. Quickstad, AMAA Chairman of AMA-ERF (American Medical Association Education and Research Foundation):

"This must be the year of the Grand Slam for the state of Illinois! It gives me great pleasure to announce that Illinois will receive not one, not two, but three AMA-ERF Awards at the convention in Chicago. The first will be for the state auxiliary with the largest contribution to AMA-ERF [\$146,433.45]. The second award will honor the Illinois State Medical Society Auxiliary for having the largest total dollar contribution, including physicians' contributions [\$179,685.45]. The third award of merit is presented to the Illinois Auxiliary for having the largest contribution per capita in the North Central Region [\$47.18]. This is truly an outstanding record and I congratulate all of you."

*How did we do it?* We did it with the sale of greeting cards, stationery, and glowworm flashlights—with raffles, auctions, and benefit dinners—with convention boutiques and holiday sharing cards. But most importantly, we did it with the leadership of two attractive and vivacious super saleswomen: Mrs. Selig Hodes (Evelyn), AMA-ERF Chairman, and Mrs. Karl Reddies (Aggie), AMA-ERF Vice-Chairman.

Auxilians from New York to California talk about the "Illinois AMA-ERF Gals," but few members realize that these two charismatic chairmen serve Auxiliary at the county level, as well as the state. Aggie, whose husband is an Internist in Freeport, has just completed her term as President of the Stephenson County Medical Auxiliary; Evelyn, whose husband is a Family Physician in Forreton, has just become Stephenson County's President-Elect. Joining the AMA-ERF leadership team this year will be another Stephenson County Auxilian, Mrs. Robert Rockey (Linda).

*Who will benefit from what we did?* The public



Mrs. Quentin L. Quickstad, (Center) AMAA chairman, American Medical Association Education and Research Foundation (AMA-ERF) presents Award of Merit for North Central Region and "Top Pair in the USA" to Mrs. Karl Reddies, (L) Freeport and Mrs. Selig Hodes, (R) Forreton.

we serve will benefit; but more specifically, the medical students, interns, and residents who were able to borrow almost \$4,000,000 this year—and the medical schools and research projects that received over \$1,000,000 this year.

At the opening session of the AMA Convention in July, Mrs. Ben Johnson, Jr., President of the AMA Auxiliary, presented the Association's Education and Research Foundation with a check for \$1,604,899.54, the largest contribution ever made by the medical family.

AMA-ERF is an exciting and rewarding business, and Illinois has two top executives who know how it's run! ◀



# Student Business Section in Action

## Luggage Or State License?

What to buy the young Illinois doctor for his medical school graduation is a perplexing problem. There are some generous individuals who might offer a new set of luggage; don't most graduates head for the "sun-belt" states? In hope of saving the luggage salesmen the burden of too many returned gifts, read further before deciding upon a present.

Of the 1762 graduates of the University of Illinois College of Medicine (U of I) from 1975-1980, 929 (52.7%) chose to remain in Illinois for residency training.<sup>1</sup> An additional 388 graduates (22%) remained in the midwest (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Ohio and Wisconsin).<sup>2</sup> Since 74.7% of U of I grads chose to stay within the midwestern area, Cohen *et al.*, concluded, "we infer that climate and culture alone do not explain why significant numbers of graduates leave Illinois."<sup>3</sup>

In comparison to ten other midwestern medical schools, Illinois state colleges of medicine have the highest retention rate of physicians who chose their residency programs from within that state.<sup>4</sup> From 1975-1978, eight state-supported and two private medical schools reported a range from 35-50% retention of graduates within the state.<sup>5</sup> Of those ten schools, U of I and Southern Illinois University Colleges of Medicine had the highest retention.<sup>6</sup> Obviously, Illinois state schools are already doing a better job than similar schools in satisfying the state's needs for recent medical graduates.

Since recent graduates are providing but a small portion of health care in Illinois, it is worthwhile to examine the composition of all doctors within our state. In 1973, the American Medical Association published statistics which described where alumni of all U.S. schools of medicine practice their art. It was seen that 64.3% of all U.S. educated Illinois physicians went to Illinois colleges of medicine.<sup>7</sup> By far, the U of I was the single largest contributor of physicians to the state.<sup>8</sup> It is interesting to note that between 1973 and 1978, the number of recent U of I grads remaining in the state increased by 10%.<sup>9</sup> Since the class sizes have remained constant, it seems that more people are choosing to remain here and that some doctors are returning after the com-

pletion of their postgraduate training.

A valid question as yet stands unanswered: "Why do Illinois medical graduates leave the state?" Grettinger and Campbell concluded that "The reason for the low number (U.S. grads) of house officers is not primarily poor retention of Illinois graduates, but the very poor attraction of other states' graduates (to Illinois)."<sup>10</sup> "... to graduates of U.S. medical schools, too few acceptable programs (in Illinois) are available, particularly in Internal Medicine, Family Practice and Obstetrics."<sup>11</sup> While university hospitals and affiliates continue to broaden their programs, Illinois still falls short of its quota of "desired residencies." To expect a graduate to remain in Illinois while better opportunities for career advancement exist elsewhere is irrational. Further, to look no farther than one's own doorstep propagates mediocrity. The greatness of American medicine stems from its innovative individuals who are willing to seek out new ideas and attempt the improbable. Patients deserve the "cream of the crop," not just warm bodies. Illinois urgently needs more high quality postgraduate training programs. It is senseless to automatically assume that Illinois educated M.D.'s will flock home after their residencies have been completed.

In 1974, Yett and Sloan surveyed the location of all U.S. medical school graduates from the class of 1966. They determined that "graduates tend to establish practice in states where previous attachment is strongest and most recent."<sup>12</sup> Therefore, it behooves educators within Illinois to upgrade and expand postgraduate medical education. This is a means for Illinois to become a more attractive center for learning and ultimately for practicing. Nationally, 51.7% of physicians remain in the state in which they completed their residency program; only 42.7% practice in the state in which they attended medical school.<sup>13</sup> Though Illinois retention rates are higher (suggesting we are doing better than the national average), there is much room for improvement.

Little can be done about our brutal winters, our

(Continued on page 135)

*This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Student Business Section.*

# A message from ...

SPECTRUM EMERGENCY CARE, INC.

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## *Legal and Ethical Aspects of Treatment*

# **The Critically and Terminally Ill Patient**

The American Society of Law and Medicine, in cooperation with ISMS, the Illinois Hospital Association and the Illinois Association of Hospital Attorneys, will sponsor a conference entitled "Legal and Ethical Aspects of Treatment for the Critically and Terminally Ill Patient." The conference will be held October 16-17, 1980 at the Chicago Ambassador West Hotel.

A distinguished roster of speakers will consider legal and moral rights of the terminally ill. The symposium is designed to provide an opportunity for physicians, attorneys, nurses, hospital administrators, ethicists and others to meet and discuss such issues as:

- Medical and Nursing Care for the Critically and Terminally Ill
- Legal Aspects of Providing and Withholding Treatment From the Terminally Ill Patient and Orders Not to Resuscitate
- Truth Telling, Obligations to Patients Who Refuse Treatment or Seek Unorthodox Treatment, and the Role of the Family
- Special Problems with Critically Ill Pediatric Patients
- Nurses' Roles and Responsibilities in the Care of the Dying
- Ethical and Practical Concerns in Hospice Care
- A Prosecutor's Concerns in Cases of Withholding or Withdrawing Medical Care

Hour-for-hour category 1 CME credit will be available to physicians.

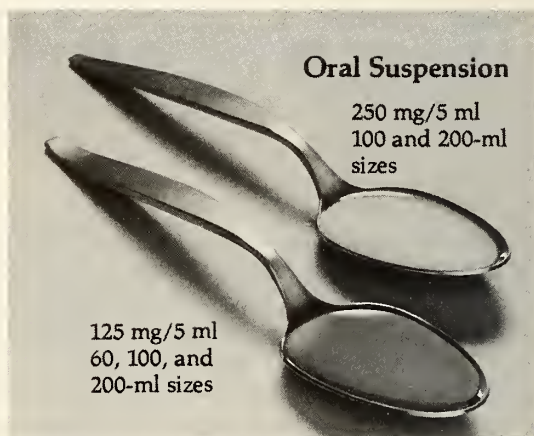
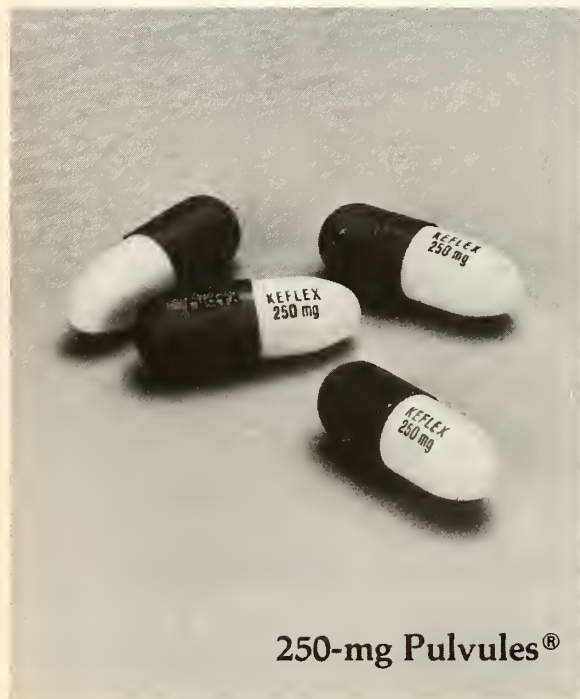
### **Registration**

Advance registration is required. The fee, which includes the conference materials and luncheon on both days, is \$110 for members of the sponsoring organizations and \$130 for non-members. To register, send your name, address, and registration fee to: American Society of Law & Medicine, TERMINALLY ILL CONFERENCE, 520 Commonwealth Avenue, Boston, MA 02215.

### **Hotel Accommodations**

A specially priced block of guest rooms has been reserved until September 24 at the Ambassador West Hotel. Reservations should be made directly with the hotel. Contact: Reservations Manager, Ambassador West Hotel, 1300 North State Parkway, Chicago, IL 60610, (312) 787-7900.

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# I M J

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## Diagnostic and Therapeutic Use of Radioisotopes in Hematology

By WILLIAM H. KNOSPE, M.D., KENNETH K. WU, M.D.  
AND JOAN WALASEK/CHICAGO

*Isotopes have been extremely valuable to diagnose a wide range of diseases. In hematology, radioisotopes such as  $^{51}\text{chromium}$  ( $^{51}\text{Cr}$ ),  $^{125}\text{iodine}$  ( $^{125}\text{I}$ ),  $^{59}\text{iron}$  ( $^{59}\text{Fe}$ ),  $^{60}\text{cobalt}$  ( $^{60}\text{Co}$ ) have been widely utilized to study red cell mass, red cell and platelet survival, plasma volume, ferrokinetic and vitamin  $B_{12}$  metabolism. The recent development of  $^{52}\text{iron}$  ( $^{52}\text{Fe}$ ) has permitted direct bone marrow scanning. By this imaging procedure, the hematopoietic activity of bone marrow, liver and spleen can be directly quantitated. Availability of the  $^{125}\text{I}$ -labeled fibrinogen has enabled clinicians to distinguish between an active and an inactive venous thrombosis. These techniques and their clinical usefulness are summarized.*

The development of nuclear reactors, cyclotrons and other types of high energy particle accelerators has permitted a cornucopia of radioisotopes which have been utilized for a variety of diagnostic and therapeutic purposes. Clinical and investigative hematology have benefited perhaps

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**KENNETH K. WU, M.D.**, is associate professor and director, coagulation thrombosis unit, department of medicine, Rush Medical College and Presbyterian-St. Luke's Hospital in Chicago. Dr. Wu is board certified in both internal medicine and hematology.

**JOAN C. WALASEK** is a medical technologist and radiohematology technician at Rush-Presbyterian-St. Luke's Medical Center in Chicago.

more than most branches of medicine from those advances in nuclear technology. Common forms of radioisotopes include alpha particle emitters, beta particle emitters and gamma emitters. Because the emissions of alpha and beta emitters have very limited paths in matter, their detection requires complicated sample preparation and instrumentation such as liquid scintillation counting. Our discussion will, with one or two exceptions, be limited to the use of gamma-emitting radioisotopes. Gamma ray emissions are detected by the following devices: (1) the sodium iodide crystal well counter which permits the detection of liquid or solid samples which fit standard 10-15 ml test tubes; (2) the external collimated sodium iodide crystal probe, which permits body surface counting of gamma-emitting radioisotopes selectively localized to specific organs, such as spleen, liver and bone marrow; (3) gamma cameras which permit instantaneous selection of gamma emissions from a relatively large surface area of the body, 9-15 inches in diameter; (4) rectilinear collimated scanners, permitting partial or whole body imaging of isotopes concentrated in bone marrow or liver and (5) small animal whole body liquid scintillation counters which permit the handling of relatively large volumes of stool, urine, menstrual pads, etc.

**Table 1**  
**Radioisotopes Used in Hematology**

<i>Radionuclide</i>	<i>Half-Life (T<sub>1/2</sub>)</i>	<i>Type of Radiation</i>	<i>Gamma Energy mev + Relative Abundance of Emission</i>
<sup>59</sup> Iron	45 days	β <sup>-</sup> , γ	1.09 (56%) 1.29 (44%)
<sup>52</sup> Iron	8.2 hours	γ, β <sup>+</sup>	0.16 (100%) 0.51 (112%)
<sup>51</sup> Chromium	27.8 days	γ	0.32 (9%)
<sup>125</sup> Iodine	57 days	γ	0.035
<sup>99m</sup> Technetium	6.0 hours	γ	0.14 (90%)
<sup>67</sup> Gallium	3.2 days	γ	0.09 (40%) 0.18 (24%)
			0.30 (22%) 0.39 (7%)
<sup>60</sup> Cobalt	5.26 days	β <sup>-</sup> , γ	1.17 (100%) 1.33 (100%)
<sup>111</sup> Indium	2.8 days	γ	0.173 (89%) 0.25 (94%)
<sup>32</sup> Phosphorous	14.3 days	β <sup>-</sup>	1.7E <sub>max</sub>
<sup>57</sup> Co	270 days	γ	0.122

Our discussion of the diagnostic use of isotopes in hematology will include the following radioisotopes: <sup>51</sup>Chromium, <sup>59</sup>Iron, <sup>99m</sup>Technetium sulfur colloid, <sup>60</sup>Cobalt-B<sub>12</sub> and <sup>125</sup>Iodine-albumin. We will also briefly consider the use of <sup>32</sup>Phosphorus in the treatment of hematologic disease.<sup>1</sup>

#### **Diagnostic Use of <sup>51</sup>Chromium (<sup>51</sup>Cr) and <sup>125</sup>Iodine (<sup>125</sup>I)**

<sup>51</sup>Cr isotope finds its major use in hematology as a label of hemoglobin in red blood cells for measurement of red cell mass and red cell survival. <sup>51</sup>Cr has also become widely used as a label of platelets for platelet survival. <sup>125</sup>I has two major diagnostic uses: (a) <sup>125</sup>I labeled albumin for determination of plasma volume and (b) <sup>125</sup>I labeled fibrinogen for diagnosis of venous thrombosis.

#### **<sup>51</sup>Cr Red Cell Mass**

<sup>51</sup>Cr-labeled red cells are prepared by incubating radioactive chromium (1.0 μ Ci/Kg body weight) with a sample of 16ml of blood drawn into 4ml of ACD anticoagulant for 30 minutes. The red cells are washed and then injected intravenously into the patient.

A red cell mass determination requires the drawing of an equilibrated sample 15 minutes after the injection of the <sup>51</sup>Cr labeled cells and the absolute amount of circulating red cells can be calculated by dilution. Determination of the red cell mass by <sup>51</sup>Cr is an important and basic part of the laboratory evaluation of a patient with erythrocytosis. Red cell mass is also commonly done by <sup>125</sup>I-labeled albumin, but the determination of red cell mass by <sup>125</sup>Iodine is only indirect and depends upon extrapolation from the plasma

volume and hematocrit. There is also leakage of albumin into the extravascular spaces which overestimates the plasma volume. This may be further accentuated by conditions associated with increased vascular permeability. A patient suspected of having erythrocytosis should always have a dual blood volume determination in which plasma volume is determined by <sup>125</sup>Iodine and red cell mass is determined by <sup>51</sup>Chromium. The performance of dual volume study may also permit the identification of the patient with stress erythrocytosis or Gaisböck's Disease. This is not true erythrocytosis but it is a pseudo-erythrocytosis often due to a contracted plasma volume.

Occasionally a red cell mass study by <sup>51</sup>Chromium will clarify a suspected anemia in which dilutional factors by an expanded plasma volume lower hemoglobin or hematocrit yet the patient has a normal amount of red cells and hemoglobin.

#### **Plasma Volume Study**

<sup>125</sup>Iodine-albumin permits the determination of the plasma volume by dilution using similar concepts as described for the red cell mass. 1.5ml of <sup>125</sup>I albumin (2-5 μC) are injected intravenously and an equilibration sample of blood taken after 15 minutes. If a dual blood volume is done, the <sup>51</sup>Chromium labeled sample of blood and the <sup>125</sup>Iodine labeled sample are injected simultaneously. The separate energy peaks of <sup>125</sup>Iodine and <sup>51</sup>Chromium (See Table 1) permit separate counting of the two isotopes by changing the discrimination of the windows on the scaler.

#### **<sup>51</sup>Chromium Red Cell Survival**

This technique is used to determine if a hemolytic process is present. It can detect hemolysis



secondary to many different hemolytic mechanisms such as autoimmunity, congenital red cell faults involving abnormal hemoglobulins, defective red cell metabolism due to enzymopathies, membrane defects such as hereditary spherocytosis and hypersplenism. Red cells are labeled with  $^{51}\text{Cr}$  similarly as in the determination of the  $^{51}\text{Chromium}$  red cell mass, but the dose is 50% more ( $1.5 \mu\text{Ci/Kg}$  body weight). Samples are drawn daily for several days and then two or three times per week until the label has dropped by 50% in the blood. This point represents the  $T_{1/2}$  or half-life of the labeled red cells. Although the absolute half-life of red cells is about 60 days, the normal  $^{51}\text{Chromium}$  half-life is about 25-30 days, due to elution of the label from the red cells. Another valuable aspect of  $^{51}\text{Chromium}$  red cell survival is determination of labeled erythrocyte splenic sequestration by counting body surface activity of labeled erythrocytes over the spleen, liver and heart. Spleen-heart and liver-heart ratios permit estimates of splenic sequestration relative to heart circulation, blood,  $^{51}\text{Chromium}$  activity and liver.

Prior to beginning the  $^{51}\text{Cr}$  survival study, the patient should be transfused up to a normal level. If red cell transfusions are given during the survival study period, the label will be diluted and an abnormally short survival obtained. If the patient is actively bleeding during the survival study, this will accelerate the disappearance of labeled cells from the circulation and give a falsely shortened  $T_{1/2}$ . If the patient must be transfused before the survival is started, the labeling of the erythrocytes should be delayed for 24 hours after the last red cell transfusion in order to permit clearance from circulation of senescent or damaged erythrocytes.<sup>2</sup> It is possible to modify the  $^{51}\text{Chromium}$  red cell survival so that labeled red cells localize only to spleen and not to liver. By heat damaging  $^{51}\text{Chromium}$  labeled erythrocytes, these erythrocytes will be removed only by the spleen. Selectively increased concentrations of heat-treated and  $^{51}\text{Chromium}$  labeled erythrocytes can be achieved and this technique may permit the visualization of small accessory spleens.<sup>3,4</sup>

#### **Gastrointestinal and Vaginal Blood Loss by $^{51}\text{Chromium}$ Labeling of Erythrocytes**

This procedure permits quantitative estimates of the magnitude of blood (and indirectly iron) loss via vaginal or gastrointestinal routes. Erythrocytes are labeled with  $^{51}\text{Chromium}$  just as for a red cell mass or red cell survival but a higher dose is used ( $2.0 \mu\text{Ci/Kg}$  body weight). After la-

beling, stools or menstrual pads are collected quantitatively. Stool samples may be homogenized for a more uniform sample. Comparison of the total amount of stool radioactivity with that present in blood as a standard permits estimate of milliliters of labeled erythrocytes on menstrual pads or in a total volume of stool. Such information can be extremely useful in assessing some patients with suspected iron deficiency anemia due to occult, intermittent G-I bleeding or heavy menstrual bleeding.<sup>5,6</sup>

#### **$^{51}\text{Chromium}$ Platelet Survival Study**

Assessment of the patient with thrombocytopenia requires a determination as to whether the thrombocytopenia is due to decreased or peripheral destruction of the platelets. If megakaryocytes are intact in the marrow we usually infer that peripheral platelet destruction is occurring. In many thrombocytopenic states, the issue of hypersplenism arises. A measurement of platelet survival may be particularly useful if splenectomy is being considered. Platelets can be labeled with  $^{51}\text{Chromium}$ . A platelet level of at least 30,000/cu mm in the blood and removal of 500cc of blood for platelet labeling is required.  $^{51}\text{Chromium}$  binds to the platelet cytoplasm and after incubation of 300  $\mu\text{Ci}$  of the isotope with the separated platelet rich plasma, platelets are washed, concentrated and injected into the patient. The normal  $T_{1/2}$  of  $^{51}\text{Chromium}$  labeled platelets is four days. Determination of spleen/heart and liver/heart ratios by body surface counting of  $^{51}\text{Chromium}$  activity may establish a component of hypersplenism in the pathogenesis of the thrombocytopenia.<sup>7</sup>

#### **$^{125}\text{I}$ -Fibrinogen Leg Scanning**

During active lower extremity thrombus formation in patients with acute deep vein thrombosis, fibrinogen is converted to fibrin which is laid down in the thrombotic site. Based on this principle,  $^{125}\text{I}$ -fibrinogen scanning technique has been successfully used in detecting active venous thrombosis. Patients should first receive oral SSKI 24 hours (five drops twice in 24 hours), or intravenous sodium iodide 100mg one hour prior to the injection of  $^{125}\text{I}$ -fibrinogen (approximately 100  $\mu\text{Ci}$ ). The patient should then be kept on SSKI three drops twice a day for 10 days. A baseline surface radioactive counting of both lower extremities will be performed one hour after the injection of radioactive fibrinogen. The surface counting will be performed by a rate-meter surface scintillation counter on the lower extremities from inguinal area to ankle with a

Table 2		
	serum iron	plasma volume
P.I.T. (mg/day/kg body weight) =	$T_{1/2}$	(ml/kg)
		100

two-inch interval between each point. Counting will then be repeated in 24 and 48 hours. It takes a minimum of 48 hours to perform the test. A positive test implies that the patient has an episode of active thrombosis. The test is particularly useful in monitoring postoperative high risk patients and in distinguishing between a true recurrent deep vein thrombosis and a postphlebotic syndrome.

#### Diagnostic Use of $^{59}\text{Fe}$ and $^{52}\text{Fe}$

**Ferrokinetic Study by  $^{59}\text{Fe}$** —The use of  $^{59}\text{Fe}$  permits classic tracer studies of iron and hemoglobin metabolism. We usually describe this sequence of tracer studies as a ferrokinetic study. The initial step involves collecting a 10ml sample of plasma and incubating it with 10-15  $\mu\text{Ci}$  of  $^{59}\text{Fe}$  (ferrous citrate) for one half hour to permit binding of the iron with the iron transport protein transferrin. Unless iron is bound to transferrin it will not enter the normal physiologic pathways of iron metabolism. After the binding of  $^{59}\text{Fe}$  to the plasma transferrin, it is injected intravenously and after equilibration, blood samples are withdrawn at 3, 10, 30, 60, and 120 minutes after injection of  $^{59}\text{Fe}$ . The plasma  $T_{1/2}$  is normally 60-90 minutes and the clearance of  $^{59}\text{Fe}$  from the plasma depends upon adequate numbers of functioning erythroid precursors which have transferrin on their cell surfaces and are avid to receive iron from the plasma transferrin. A prolonged clearance of  $^{59}\text{Fe}$  may indicate a deficiency of erythroid precursors as in aplastic anemia and an accelerated clearance of iron may indicate erythroid hyperplasia secondary to iron deficiency or a hemolytic process. The next step in the ferrokinetic process is to measure the incorporation of  $^{59}\text{Fe}$  into functioning erythroid precursors, usually in the marrow but sometimes in liver or splenic tissue. This uptake of  $^{59}\text{Fe}$  by marrow is done by body surface counting with an external gamma probe over marrow, spleen, liver and heart. In a normal subject, there is very little radioactivity detected over spleen or liver while there is a progressive rise in radioactivity over the marrow, reaching a peak at three days. As the iron radioactivity falls off with clearance from the

plasma, it rises in the marrow. Radioactivity then falls off over marrow as the  $^{59}\text{Fe}$  is incorporated into erythroid precursors which then differentiate into mature erythrocytes which are released from the marrow into the blood over a three to five day period. As the  $^{59}\text{Fe}$  radioactivity declines in the marrow, radioactivity in circulating erythrocytes increases. The measurement of  $^{59}\text{Fe}$  in circulating blood erythrocytes assesses the incorporation of  $^{59}\text{Fe}$  into hemoglobin and into the mature circulating erythrocyte. Normally 70-95% of the injected  $^{59}\text{Fe}$  is incorporated into circulating red cells and this part of the ferrokinetic study becomes the most important indicator of whether erythropoiesis is effective or not. In many refractory anemias, plasma  $^{59}\text{Fe}$  clearance is normal or even increased, uptake of the isotope into the marrow is normal and yet  $^{59}\text{Fe}$  incorporation is markedly reduced. This is the classic pattern of ineffective erythropoiesis. Ferrokinetics can be quantified by calculating the plasma iron turnover rate (P.I.T.).<sup>8-10</sup> (See Table 2)

**Total Body Marrow Scanning by  $^{52}\text{Fe}$** — $^{59}\text{Fe}$  is an ineffective isotope for marrow scanning because its high energy gamma emission makes collimation difficult and imaging rather blurred. Anger pioneered the use of  $^{52}\text{Fe}$ , a proton emitting isotope, for bone marrow and hematopoietic organ imaging. The positron decays rapidly into two more manageable low energy gamma emissions which form an angle  $180^\circ$  apart. This property permits more efficient collimation and localization of the isotope (particularly with coincidence circuitry). Although  $^{52}\text{Fe}$  marrow imaging was initially used with the gamma camera and coincidence counting which reduced the effects of scatter, more recent linear scanning devices have permitted relatively rapid whole body scanning of marrow and hematopoietic organs. Total body marrow scanning has been used for several purposes. The natural history of the radiation induced marrow lesions in patients receiving curative doses of radiotherapy for lymphomas was studied. We demonstrated that significant marrow regeneration and scan normalization usually occurred within one to two years after completion of radiotherapy. Blood counts re-



turned to normal within the same period. Histologic study of irradiated marrow from  $^{52}\text{Fe}$  scanned patients also showed recovery; although patchy aplasia was usually seen. These studies indicated that marrow recovery does occur after 4000-5000 rad doses to the marrow but that the recovery is delayed. The  $^{52}\text{Fe}$  marrow scan may also be used to differentiate between radiation induced cytopenias and chemotherapy induced cytopenias. The demonstration of intact normal marrow outside the radiation fields might point to hypersplenism or radiation as the cause of the cytopenias. Combination chemotherapy may be necessary after radiotherapy in patients with lymphoma but concern for diminished marrow reserve may delay or result in failure to administer chemotherapy. Our studies indicate that chemotherapy is probably feasible if it is delayed by a year or more after curative doses of radiotherapy. Clinical experience with administration of combination chemotherapy to irradiated patients with lymphoma has validated the conclusions about marrow recovery based on the scanning data. Total body marrow scanning in patients with radiation induced marrow aplasia (or in idiopathic aplastic anemia) may permit better prognosis of marrow regeneration, particularly if serial scans can be done.<sup>14,16</sup>

We have also found  $^{52}\text{Fe}$  scanning useful in studying patients with myeloproliferative disorders. Common to all of these diseases—polycythemia rubra vera, myelofibrosis, chronic granulocytic leukemia and essential thrombocytosis—is the presence of active marrow in the long bones. This finding or the documentation of myeloid metaplasia in spleen or liver can be very useful in diagnosis or management of some patients with myeloproliferative disorders.

To do  $^{52}\text{Fe}$  marrow scanning requires the proximity of a cyclotron and cooperation of cyclotron operators who must commit a very expensive machine to a use often irrelevant to a physics program. Alternative methods of marrow scanning utilize  $^{99\text{m}}\text{Tc}$  Technetium sulfur colloid which is deposited in the reticuloendothelial organ whose distribution is similar to the hematopoietic tissue in marrow or in liver or spleen. When a technetium marrow scan is done, hematopoietic function can only be inferred, rather than directly measured as in the iron scans.  $^{111}\text{In}$  is closely related chemically to iron and at least partially follows iron along transferrin pathways to erythroid precursors and possibly hemoglobin. It is actively taken up by the R.E. system and occasionally may be concentrated in tumors.  $^{111}\text{In}$  scans of marrow represent an alterna-

tive for  $^{52}\text{Fe}$  to assess the functional activity and distribution of hematopoietic tissue.

### Tests For $\text{B}_{12}$ Absorption— $^{60}\text{Co}$ Cobalt

**Schilling Test**—The use of the Schilling Test involves administering an oral dose of  $^{60}\text{Co}$  Vitamin  $\text{B}_{12}$ . If the patient has adequate gastric mucosal function and makes intrinsic factor, the labeled vitamin  $\text{B}_{12}$  will bind to intrinsic factor which will then facilitate absorption of the intrinsic factor— $\text{B}_{12}$  complex across small bowel mucosa, be bound to transcobalamine II, the plasma transport protein for vitamin  $\text{B}_{12}$  which then carries it to most dividing cells and stores excess in the liver. To block storage of the labeled vitamin in the liver we then give a flushing dose of cold non-labeled vitamin  $\text{B}_{12}$  which causes a significant part of the labeled vitamin to be excreted into the urine. If the Schilling Test is abnormal it should be repeated with intrinsic factor by mouth. An abnormal Schilling Test due to pernicious anemia should be corrected with intrinsic factor. A Schilling Test not corrected with intrinsic factor would indicate a small bowel lesion causing malabsorption of vitamin  $\text{B}_{12}$ . The Schilling Test for adequacy of intrinsic factor function depends upon adequate renal function. It also requires a cooperative patient able to collect all his urine and dependable ward personnel able to collect a 24-hour urine sample and deliver it to the radioisotope laboratory. A breakdown in this sequence of dependable patient, ward personnel and transport personnel can confound performance of the Schilling Test.<sup>11</sup>

**Jerzy-Glass Test**—Our laboratory offers the Jerzy-Glass Test as an alternative to the Schilling Test. This test involves administration of a labeled oral dose of  $^{57}\text{Co}$  Vitamin  $\text{B}_{12}$  just as in the Schilling Test. We then measure uptake of the labeled Vitamin  $\text{B}_{12}$  over the liver. The Jerzy-Glass test does not require urine collection or careful cooperation of patient and ward personnel and it does not depend upon normal kidney function. If the test shows a decreased uptake of labeled vitamin over the liver, it should be repeated with a dose of intrinsic factor to determine if the defect in  $\text{B}_{12}$  absorption is corrected.<sup>12</sup>

### Miscellaneous Isotopes

Patients with hematologic disorders, particularly hematologic malignancies, are frequently subjected to a variety of isotopic scanning procedures.  $^{99\text{m}}\text{Tc}$  Technetium sulfur colloid liver-spleen scans,  $^{67}\text{Ga}$  Gallium and  $^{111}\text{In}$  Indium-bleomycin scans for the identification of occult or suspected lymphomatous disease are frequently per-

formed.<sup>13-14</sup>

**Interference of One Isotope with Measurement of Other Isotopes**—The great expansion in number of radionuclides available for clinical use not infrequently results in the interference by an isotope present from a previous test with a test to be done. The interval required before the desired isotope study can be started will depend upon the physical decay of the isotope and its biological decay which depends upon excretion. The administration of long-lived isotopes like <sup>51</sup>Cr, <sup>59</sup>Fe and <sup>67</sup>Ga may require a delay of weeks before a subsequent isotope test can be done. It is not uncommon for patients with hematologic malignancies to have a <sup>67</sup>Gallium scan for staging. In the course of diagnostic workup on such patients hypersplenism may be suspected and a <sup>51</sup>Chromium red cell survival ordered, only to find that the test cannot be done for weeks. Similarly, prior administration of <sup>60</sup>Cobalt may delay <sup>59</sup>Iron studies. Careful consideration of the overall clinical situation and anticipation of what isotopic studies may be required is increasingly necessary to save patients needless and expensive delays in the time required to complete a period of hospital study. Isotopes with low energies and short half-lives should be used first, reserving isotopes with high energies and long half-lives for last. Consultation with the nuclear medical specialist, hematologist or oncologist may be necessary to set priorities for isotopic study and finally decide what can be done in a limited time.

**Therapeutic Use of Radiophosphorous (<sup>32</sup>P)**—Osgood pioneered the use of <sup>32</sup>P as a therapeutic agent in hematology. This isotope provides smooth, gradual and long-term control for a variety of hematologic malignancies such as polycythemia rubra vera, chronic granulocytic leukemia, chronic lymphocytic leukemia and essential thrombocytosis. The excessive production of red cells, leukocytes and platelets in the marrow and other hematopoietic organs can be suppressed by the bone seeking beta-emitting <sup>32</sup>P. The isotope is administered intravenously in initial doses of 20-40  $\mu$ Ci/kg and then the dose repeated after four to six weeks with monitoring of the appropriate cell series to be depressed—red cells, leukocytes or platelets. If the cell line being treated is still abnormally elevated, the dose is titrated up by 10%. Such an approach to therapy had the advantage of permitting the physician to know precisely what therapy the patient received and relieved the patient of the burden of drug compliance. Modan's report of a 10 fold increase in the incidence of acute leukemia in P.R.V. patients treated with <sup>32</sup>P led to the virtual abandon-

ment of <sup>32</sup>P as a therapeutic agent in hematology. The P.R.V. Study Group under the leadership of Dr. Louis Wasserman has reassessed <sup>32</sup>P in P.R.V. and shown that there is no greater risk of developing acute leukemia with <sup>32</sup>P than with alkylating agents, particularly chlorambucil. This recent development may give <sup>32</sup>P a new lease on life for P.R.V., thrombocytosis and other hematologic disorders. ◀

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Revision of *The School Code of Illinois*

## HEALTH EXAMINATION AND IMMUNIZATIONS

BY MS SHARON ELVIDGE

*The School Code of Illinois now requires that all students in public, parochial and private schools present proof of immunity against diphtheria, pertussis (through age five), tetanus, poliomyelitis, rubeola, and rubella.*

*Immunization against rubella is required for **all** males and for females through the age of nine. Mumps vaccine is strongly recommended, but not required by law at this time. All Students also must have a physical examination. The only exceptions to these requirements are for medical or religious reasons.*

On August 13, 1979, Governor Thompson approved H.B. 2301 (PA 81-184). The statute clarified and strengthened immunization and health examination requirements and became effective on that date.

As with any new statute, there has been some confusion regarding the interpretation and implementation of the new provisions. The following information is from the Illinois State Board of Education (ISBE) and the Illinois Department of Public Health (IDPH) concerning the implementation of Public Act 81-184.

This statute applies to all public, private and parochial school students in Illinois. It requires that each child present proof of having had a health examination and documented proof of immunization in accordance with PA 81-184 and the rules and regulations of the Illinois Department of Public Health.

A physical examination is to be conducted within one year prior to entering school for the first time, within one year prior to entering nursery school, kindergarten or first grade, and again within one year prior to entering the fifth and ninth grades. (In schools where grade levels are not assigned, the ages of five years, ten years and 14 years of age are required for health examinations.) Additional health examinations may be required when deemed necessary by school authorities. *All* students are required to have a physical examination on file. If a student did not have a physical exam at kindergarten or first grade, or fifth or ninth grade, and is past that grade level, he or she must have a physical examination prior to entering school this fall (1980).

IDPH is charged by PA 81-184 with responsibility for promulgation of rules and regulations concerning requirements for child health examination, which includes physical examinations, immunizations, and hearing and vision screen-

ing; and for dental exams when required by local school board policy. The department has established requirements for health examinations. Health examinations must be performed and signed by a physician licensed to practice medicine in all its branches (also includes osteopaths). A registered nurse may perform any part of an examination under proper protocol; however, a physician must review and sign the examination form. The physician is responsible for all portions of the examination except dental and hearing/vision screening sections.

The hearing/vision screening exam must be performed in accordance with IDPH rules and regulations, by persons certified by IDPH.

Health examination forms used should be the uniform form the IDPH and the Illinois State Board of Education prescribe for statewide use. The form is the Certificate of Child Health Examination (DCFS, IOE, IDPH, IDPA, 001, 3/79). The examiner should also summarize on the report form any condition he/she suspects indicates a need for special services. This form has been in circulation for some time and as of May 1, 1980, was available from the Regional Superintendent's office. The IDPH provides these forms (free of charge) to all Regional Superintendents. In the 1980-81 school year, substantial compliance with the use of this health form will be required for children entering kindergarten or first grade, fifth and ninth grades and for any student who has not received a physical at the appropriate grade level or since. In the 1981-82 school year and thereafter complete compliance in using this form will be required for those students mentioned above. (The health form will be revised prior to the 1981-82 school year and revised forms will be distributed to the Regional Superintendent's office in the fall of 1980.)

Each child shall present to the local school authority proof of having received the required immunizations. Proof of immunization is a document or statement signed by a health care provider indicating the type of vaccine administered and the date the immunization was received. Month and year are necessary in most instances to show proof that the immunizations were received at the appropriate time interval or later. The statement should be presented to the school by the child's parent or legal guardian. (This information must be on file for *every child* in school.)

By 1980, 80 percent of all pupils (in all grades) in each school district are to be in compliance with health examinations and immunization requirements. By 1981, and each year thereafter, 90 percent compliance levels are required.

Parents or legal guardians who object to immunizations or health examinations for their children, on religious grounds, must submit a written statement to local school authorities detailing such objection. General philosophical or

moral reluctance to allow immunization or physical examination will not provide a sufficient basis for an exception to statutory requirements.

Exceptions may be made to immunization requirements on the basis of medical contraindications. If one or more of the required immunizations is medically contraindicated, the examining physician must record any contraindication and reason for contraindication on the examination form. Should the condition of the child later permit immunization, this requirement will then have to be met.

It is intended that with the combined resources of state and local health providers and educators, public and private physicians, the objectives of this law will be met and maintained, and thus, the children of Illinois will have an opportunity to obtain an education in a healthful environment.

For information or questions concerning this article contact Ms. Sharon Elvidge, School Health Section Chief, Division of Health Promotion and Screening, Illinois Department of Public Health, Springfield, Illinois, 217/782-4733. ◀

The following definitions have been developed by the Illinois Department of Public Health to clarify the difference between (1) being protected against diseases and in compliance, (2) being unprotected and in compliance, and (3) being unprotected and in noncompliance.

In addition to being in compliance relative to immunizations, children must receive physical examinations prior to entering Illinois schools for the first time, prior to entering fifth grade, and prior to entering ninth grade. Children who have *not* received physical examinations, as required, are considered to be in noncompliance regardless of whether or not they have received necessary immunizations.

POLIO (TOPV)			
	PROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN NON-COMPLIANCE
Nursery School (Age 2 Or Older)	Has received three or more doses of TOPV with the last dose being a booster.	Has received at least one dose of TOPV, but fewer than those required to be <i>PROTECTED AND IN COMPLIANCE</i> , but has presented schedule from a physician or clinic to complete the required doses; or a statement that these immunizations are medically contraindicated; or has presented a statement detailing the parent(s)' or guardian(s)' objection on religious grounds.	Has received fewer than the required immunizations and has not presented a schedule from a physician or clinic for receiving these immunizations, nor a statement that these immunizations are medically contraindicated, nor a statement detailing the parent(s)' or guardian(s)' objection on religious grounds.
Kindergarten Or First Grade	Has received three or more doses of TOPV with the last dose being a booster and having been received on or after the 4th birthday but prior to school entrance.		
6 Years Of Age Or Older	Has received three or more doses of TOPV with the last dose being a booster <i>and</i> having been received on or after the 4th birthday.		

DIPHTHERIA, TETANUS, PERTUSSIS (DTP)			
	PROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN NON-COMPLIANCE
Nursery School (Age 2 Or Older)	Has received four doses of DTP with the last dose being a booster.	Has received at least one dose of DTP or Td, but fewer than required to be <i>PROTECTED AND IN COMPLIANCE</i> but has presented an	Has received fewer than the required immunizations and has not presented a



Kindergarten Or First Grade	Has received four or more doses of DTP with the last dose being a booster <i>and</i> having been received on or after the 4th birthday but prior to school entrance.	individual schedule from a physician or clinic to complete the required doses; or a statement that these immunizations are medically contraindicated; or has presented a statement detailing the parent(s)' or guardian(s)' objection on religious grounds.	schedule from a physician or clinic for receiving these immunizations, nor a statement that these immunizations are medically contraindicated, nor a statement detailing the parent(s)' or guardian(s)' objection on religious grounds.
6 Years Of Age Or Older	<p>1. Has received three or more doses of DTP or Td with the last dose being a booster <i>and</i> having been received on or after the 4th birthday.</p> <p>2. If 10 years have elapsed since the last booster, an additional booster is required.</p>		

#### MEASLES (RUBEOLA)

	PROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN NON-COMPLIANCE
Nursery School (Age 2 Or Older)	Has received measles vaccine at 15 months of age or later, or had the disease.	Has not received measles vaccine as required, nor had measles disease, but has presented a statement from a physician or clinic that this immunization is medically contraindicated, or a statement from the parent(s) or guardian(s) detailing objections on religious grounds.	Has not received the vaccines as required, nor had the disease; and has not presented a schedule from a physician or clinic for receiving these immunizations, nor a statement that these immunizations are medically contraindicated nor a statement detailing the parent(s)' or guardian(s)' objection on religious grounds.
Kindergarten Or First Grade	Has received measles vaccine at one year of age or later, or had the disease.		
6 Years Of Age Or Older	Has received measles vaccine at one year of age or later, or had the disease. If immunization was received prior to 1968, proof must be provided that a live virus vaccine was given.		

#### RUBELLA (3 DAY)

	PROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN COMPLIANCE	UNPROTECTED AND IN NON-COMPLIANCE
Nursery School (Age 2 Or Older)	Has received rubella vaccine at one year of age or later.	Has not received rubella vaccine as required, but has presented a statement from a physician or clinic that this immunization is medically contraindicated or a statement from the parent(s) or guardian(s) detailing objections on religious grounds.	Has not received the required vaccine, and has not presented a schedule from a physician or clinic for receiving these immunizations, nor a statement that these immunizations are medically contraindicated, nor a statement detailing the parent(s)' or guardian(s)' objection on religious grounds.
Kindergarten Or First Grade			
6 Years Of Age Or Older	Has received rubella vaccine at one year of age or later.	<p>Has not received rubella vaccine and is a female age 10 or over.</p> <p>Rubella vaccine is <i>not required</i> for females age 10 or older.</p>	

#### MUMPS

Mumps vaccine is recommended but *not required* by the Illinois Department of Public Health. A child is protected if vaccine was received at one year of age or later if the child had the disease.

\*Children entering kindergarten or first grade in school year 1981-82 and thereafter, must have received measles vaccine at 15 months of age or later or had the disease.

## Demography and Diagnoses

# Psychiatric Disorders in a Student Health Service

BY LEE SPALT, M.D./CARBONDALE

*Two hundred and sixty-four student psychiatric referrals were evaluated by the same interviewer using a detailed, precoded questionnaire based on the diagnostic criteria of Feighner et al. The female sex and older age group (22 to 40 years) were associated with referral for evaluation. Marital status was not.*

*Psychiatric diagnoses for the university student psychiatric referrals were compared with the findings for a nonstudent psychiatric outpatient group. The student group had less severe illness (schizophrenia) and more nonprescription drug use. Less primary and more secondary affective disorders were present in the student group, a finding thought to be related to the increased presence of drug use before the onset of affective symptoms.*

The lack of needed research in the area of student mental health has been lamented by Payne.<sup>1</sup> Rook has said, "... information and statistics are the bricks and mortar of prevention, and until mental disease in University undergraduates is regarded in the same way as other illness... it is unlikely that much progress will be made in preventing its recurrence."<sup>2</sup>

The prevalence of severe psychiatric illnesses (psychoses, severe psychoneuroses and major personality disorders) in University students has been reported to be from 1-5%.<sup>3-8</sup> Milder disturbances (psychosocial, psychosexual and psychosomatic problems) are thought to be present for from 10-20% of the University student population.<sup>4-14</sup>

Sex related differences for first year prevalence of psychiatric disorders were reported by Kidd<sup>15</sup> with from 9-9.1% for men and from 13.6-14.6% for women at the University of Edinburgh and Belfast, respectively. Malleison<sup>4</sup> and others<sup>16</sup> have noted that the more severe psychiatric illnesses tend to present in the first term of the first year of college.

Hudgens studied psychiatrically ill and well adolescents and found them to be "similar with respect to sex distribution, race and marital status."<sup>17</sup> There is a lack of data about prevalence of specific psychiatric disorders in student populations. Tuason studied the presence of specific disorders in 1,086 first admission psychiatric inpatients taken from the general population.<sup>18</sup> Others have reported similar data for psychiatric outpatients from the same population.<sup>19</sup> The distribution of specific illnesses in the populations will be discussed.

### Hypotheses

The demographic characteristics of sex, age and marital status are hypothesized to differ for university student psychiatric patients versus the university student population at risk.

The prevalence of specific psychiatric illnesses in the students referred to the Health Service's psychiatric clinic is hypothesized to differ from the prevalence of those disorders in a group of nonstudent psychiatric outpatients.

### Method

Comprehensive, structured interviews covering all details of the Feighner, *et al.*, diagnostic criteria<sup>20</sup> for psychiatric research were administered uniformly to all (264) university students seen for psychiatric evaluation during two consecutive years at a university health service psychiatric clinic.

The study sample included only new referral patients referred by other health service physicians or university psychologists seeing clients at

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two separate university counseling centers. The precoded interview data was punched into cards, transferred to tape and compiled by computer. The significance of findings was tested by the Chi-square method and when appropriate, the Chi-square with the Yates correction method.

### Results, Data And Discussion

University student population data supplied by the office of the registrar provided demographic characteristic approximations for the population at risk. For the two year study period from July 1, 1972, through June 30, 1974, approximately 26,457 students were registered for classes at some time and were eligible for psychiatric evaluation referral. Two hundred and sixty-four (1%) of the students were actually referred for psychiatric evaluation. Not all of those 264 patients suffered severe psychiatric illness. This suggests that the prevalence of severe illness was lower than the 1—5% reported by others, that not all severely ill patients were coming to the attention of the student health service, or that such patients were being treated with counseling or psychotherapy by another university clinic or center.

Significantly more women than expected were evaluated ( $p < 0.005$ ). Women represented 38% of the total student population and 47% of the student psychiatric referrals as shown in Table 1. Our findings indicate that 1.2% of the university women students and 0.9% of the male students came for evaluation. The female to male ratio of 1.3 to 1.0 is similar to the ratio of 1.6 to 1.0 reported by Kidd.<sup>15</sup>

Age distribution differences were demonstrated with more older, (22 years old and older) individuals in the psychiatric population than were expected ( $p < 0.0005$ ). The patient group showed consistently fewer persons in each year group of 21 and under. Our findings seem to contradict those of Malleson<sup>4</sup> and others<sup>16</sup> who suggested psychiatric illness was more likely seen in younger students early in their college careers.

Marital status distributions were the same for both groups with 17% married and 83% unmarried. Marital status did not seem to be related to the presence of psychiatric illness, a finding in agreement with Hudgens.<sup>17</sup>

A diagnosis of drug use was entered for more patients (75%) than any other single diagnosis. All affective disorders (unipolar primary, bipolar primary and secondary affective disorders combined) were diagnosed for 71% of the psychiatric referral patients. Of the 187 affective disorder patients, most (74%) had affective disorders

Table 1  
Demographic Characteristics

	Population at Risk	Uni. Student Psychiatric	Probability
N	26,457	264	
SEX	%	%	
Female	38	47	<.005
Male	62	53	
AGE			
Under 22	58	46	<.0005
22 & over	42	53	
MARITAL STATUS			
Married	17	17	NA
Unmarried	83	83	

which were thought to be secondary while only 26% were identified as primary affective disorders. Of the 48 primary affective disorders, 77% were unipolar, having had depressions without manic episodes. Eleven (23%) of the primary affective disorder patients gave a history of symptoms meeting criteria for the bipolar or manic-depressive illness.

Alcoholism was present in 28% of the referred student patients. Antisocial personality (17%) and hysteria (15%) were the next most frequent diagnoses.

The 264 patients gave histories meeting criteria for 606 different psychiatric diagnoses including 14 patients (5%) with undiagnosed psychiatric illness and 7 persons (3%) with impressions of "no psychiatric illness." There were an average of 2.3 psychiatric diagnoses per patient. No individual patient's history met diagnostic criteria for more than 5 impressions.

Table 2 compares to two study groups: The present study group of 264 university student psychiatric patients and the Wohl Clinic study of 154 psychiatric outpatients from the general population.<sup>19</sup> Both studies were based in the same general midwestern geographic area.

Diagnoses of alcoholism remained most constant at approximately 1/4 (23 to 28%) for both groups. The prevalences of schizo-affective illness, alcoholism, antisocial personality, hysteria, anxiety neurosis, sexual deviations, organic brain syndromes, undiagnosed psychiatric illness, and no psychiatric illness were similar for the student and the non-student psychiatric outpatient population. The more severe psychiatric illnesses, unipolar and bipolar primary affective disorders, and schizophrenia were all less prevalent for

Table 2

## Diagnoses

N	General Psychiatry Outpatient Clinic	University Student Psychiatric Referrals	Probability
	154	264	
	<u>%</u>	<u>%</u>	
Affective disorder	75	71	NS
Primary	39	18	<.0005
Unipolar	27	14	<.005
Bipolar	12	4	<.005
Secondary	36	53	<.005
Schizophrenia	8	3	<.01
Schizo-Affective Illness	5	2	NS
Alcoholism	23	28	NS
Drug Use	14	75	<.0005
Antisocial Personality	17	17	NS
Hysteria	16	15	NS
Anxiety Neurosis	5	5	NS
Sexual Deviation	3	4	NS
Organic Brain Syndrome	3	—	NS
Obsessive-Compulsive Dis.	*	1	*
Phobic Disease	*	2	*
Mental Retardation	5	—	<.005
Undiagnosed Psychiat. Ill.	3	5	NS
No psychiatric illness	5	3	NS

\*Not available

the student psychiatric patients as was mental retardation. Only two disorders, secondary affective disorder and drug use, were more prevalent for the student patients.

Because mood disorders which would otherwise meet criteria for primary affective disorders are diagnosed as secondary if their onset chronologically follows the onset of drug use or other disorders, it is suggested that the increase in secondary and decrease in primary affective disorders in the student psychiatric referrals might represent a function of increased early drug use in that group or the population at risk. When primary and secondary affective disorders are combined the prevalence of any affective disorder does not vary significantly for the compared student and nonstudent psychiatric groups (71 versus 75%). It would then follow that the only significant diagnostic differences were those of less schizophrenia and mental retardation and more nonprescription drug use in the student patients. It is suggested that the presence of

schizophrenia may carry disadvantages causing a natural selection making college entrance less likely for persons with that disorder.

### Conclusion

Women students were referred for psychiatric evaluation more often than men ( $p < 0.005$ ). Psychiatric referrals were more often made for older students (22 to 40 years old) than for students less than 22 years old. Marital status was not related to referral for psychiatric evaluation.

Severe psychiatric disorders (primary affective disorders and schizophrenia) were less often seen in the student psychiatric referrals than in a group of nonstudent psychiatric outpatients. Schizo-affective illness, alcoholism, neuroses, personality disorders, sexual deviations, organic brain syndrome, undiagnosed psychiatric illness and no psychiatric illness were all as prevalent as in a nonstudent psychiatric outpatient population. Only nonprescription drug use and secondary affective disorders were seen more often in the student group. ◀



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## Obituaries

**\*Blome, W. Nelson**, died July 2, 1980, at the age of 72. Dr. Blome, a 1937 graduate of the Loyola University Stritch School of Medicine, had practiced in Rockford. He had been honored with a plaque, presented at the 1980 ISMS Annual Meeting by then-president P. John Seward, M.D., for service to ISMS in covering their joint practice during Dr. Seward's term in office.

**\*\*Ford, William K.**, Rockford, died July 19, 1980, at the age of 54. Dr. Ford, a 1924 graduate of the Loyola University Stritch School of Medicine, was a past president of the Winnebago County Medical Society and former chairman of the ISMS Delegation to the AMA.

**\*Larmon, William A.**, Chicago, died July 17, 1980, at the age of 63. Dr. Larmon was a 1942 graduate of Northwestern University Medical School.

**\*\*Moellenhoff, Fritz**, Chicago, died July 22, 1980, at the age of 89. Dr. Moellenhoff was a 1917 medical school graduate from Wurtemberg, Germany.

**\*Tompkins, Charles A. Jr.**, Chicago, died July 20, 1980, at the age of 54. Dr. Tompkins was a 1948 graduate of Howard University in Washington, D.C.

**\*Webb, Edward F.**, Skokie, died July 23, 1980, at the age of 64. Dr. Webb was a 1940 graduate of the University of Illinois Abraham Lincoln School of Medicine.

\* Indicates ISMS member

\*\*Indicates ISMS member of the fifty year club

# Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

## Arthritis/Dermatitis Syndrome - Part I

GORDON TRENHOLME, M.D./CHICAGO, *Contributing Co-Author*

A 27-year-old female was seen for joint pains and a skin rash. Earlier that day she had noted onset of right knee pain on standing. This progressed over several hours to include local swelling and tenderness and weightbearing became increasingly difficult. Pain at the base of her left thumb soon followed, with limitation of motion at her wrist, and was accompanied by chills and sweats. Simultaneously, she noted a few non-puritic eruptions on her forearms and thighs. Later that day, right elbow pain had also begun.

She was otherwise healthy and on no chronic medications. Past history included two normal vaginal deliveries and an uncomplicated tubal ligation. Aside from a recent menstrual period and a mild vaginal discharge, review of systems was unremarkable. She denied diarrhea, burning on urination, recent sore throats, oral or vaginal ulcerations, or previous bouts of arthritis or dermatitis. She denied any drug allergies or recent ingestions. Family history was noncontributory.

On examination, temperature was 38.5°C and pulse was 116 beats per minute; blood pressure and respiratory rate were normal. Skin exam revealed several small erythematous papular lesions, some pustular in nature, on her forearms and thighs. Joint exam revealed local tenderness and swelling about the left radial styloid and dorsum of the left wrist, with motion restricted and painful. The right knee was warm, and intraarticular fluid was present. The knee was flexed and complete extension impossible. The right elbow appeared unremarkable except for mild local pain with motion. No swelling was obvious. Pelvic exam was normal except for a small white discharge from the cervical os. Remaining physical examination was unrevealing.

### Laboratory

Hematocrit was 39%. White blood count was 11,200 with 85% polymorphs. SMA 18, EKG, urinalysis and chest Xray were normal. An RPR

was nonreactive. Xrays of wrists and elbows were normal bilaterally. X-rays of knees showed evidence of effusion on the right, but were otherwise unremarkable. Sedimentation rate was 63mm/hour westergren. Rheumatoid factor and anti-nuclear antibodies were absent from serum. Right knee aspiration yielded 40cc's of turbid, cloudy fluid with poor viscosity. Analysis of synovial fluid revealed: WBC count 39,800 with 94% polymorphs; RBC count 1200; absent crystals; glucose 26. A simultaneous serum glucose was 98. Gram stain and culture of skin lesions and synovial fluid, as well as three blood cultures, were unrevealing. Urine culture was sterile. Cervical, pharyngeal, rectal and urethral cultures for *N. gonorrhoea* were obtained and were positive for the organism in both rectum and cervix.

### Comment

Blood stream spread of *N. gonorrhoea* from local mucosal membrane sites occurs in 1-3% of patients with local gonococcal disease, and leads to the clinical syndrome of disseminated gonococcal infection (DGI).<sup>1</sup> Articular and dermatologic manifestations dominate the clinical picture,<sup>1,2</sup> and result from hematogenous spread of the organism to skin and synovium. The arthritis is acute, asymmetric, and migratory, affecting both large and small joints. Two or more joints are involved in most patients. True migration, with one joint improving while another is exacerbating, often occurs. Monoarticular disease may occur in 16-35% of cases, and tenosynovitis, especially about the wrist, is also common. Dermatologic manifestations occur in many patients, and may be the first clinical clue to illness. Red papules 2-5mm in size appear on the extremities, 5-30 in number, and can be seen in varying degrees of progression from papular to pustular or hemorrhagic lesions. Rarely, other sites such as heart valves or meninges become involved as a result of gonococcal sepsis.



Two clinical patterns of presentation have been identified: an early "bacteremic" stage characterized by polyarthritides, dermatitis, constitutional symptoms, positive blood cultures and negative joint cultures; and a later "septic joint" stage with monoarticular arthritis, positive joint and negative blood cultures, and an absence of symptoms of systemic sepsis.<sup>3</sup> Patients may present with either pattern. However, a spectrum of presentations between the two patterns exists with overlapping features common to each.<sup>4</sup> Local mucosal infections of *N. gonorrhoea* are usually asymptomatic at the time of DGI, and absence of such symptoms are not a clue against DGI. Although females predominate, males are involved in DGI in up to 40% of cases.<sup>4</sup>

Diagnosis is based on evidence of *N. gonorrhoea* from a disseminated site. Gram stain and culture of skin pustules and synovial fluid, as well as blood cultures, should be done routinely on chocolate agar medium. Recovery from these sites is often poor, however, even in the face of active disease.<sup>5</sup> Diagnosis must then be inferred from other criteria such as typical clinical presentation and/or positive gram stain or culture from a mucous membrane site. For this reason, culture of the pharynx, urethra, rectum and cervix on Thayer-Martin medium should be done routinely when DGI is suspected. A "septic" appearing synovial fluid with a high WBC and polymorph count and a low synovial fluid to serum glucose ratio (normal 90%) are suggestive. The presence of predisposing factors<sup>1</sup> to DGI such as pregnancy or recent menses may also be useful. DGI should be considered in any sexually active person with acute onset of typical arthritis, dermatitis or tenosynovitis, and therapy begun presumptively after appropriate cultures are taken if suspicions are high.

Penicillin remains the therapy of choice for DGI,<sup>6</sup> with only rare resistant strains reported.<sup>7</sup> Dosages are variable. Treatment is initiated with 10-20 million units of aqueous penicillin per day administered intravenously for 10 days. Two grams of oral ampicillin per day may be substituted when a clinical remission has occurred. So effective is penicillin that response to it may often be considered additional evidence for DGI when cultures from disseminated sites are negative.<sup>5</sup> In penicillin-allergic patients or with resistant organisms, tetracycline, erythromycin or spectinomycin have been substituted with adequate effectiveness. Joints involved should be treated as septic joints with repeated aspirations as needed to remove purulent material, and immobilization. Response is usually prompt, but may be delayed up to 10 days on occasion.<sup>6</sup> Joint

destruction is uncommon unless institution of antibiotics is unduly prolonged. Adequacy of therapy on local mucosal reservoirs of *N. gonorrhoea* must be assessed by reculture post therapy, and sexual contacts should also be evaluated.

## Conclusion

Acute febrile onset of an asymmetric arthritis and tenosynovitis, together with typical skin lesions, allowed a presumptive diagnosis of DGI in this sexually active young female. The presence of a high synovial fluid white count and low synovial fluid glucose supported the notion of a septic arthritis, and her recent menses further suggested *N. gonorrhoea* as the organism involved. After appropriate cultures she was placed on 2.5 million units of aqueous penicillin IV Q6 hours. Within 24 hours joint symptoms had improved and no new skin lesions were noted. Within five days, complete resolution of arthritis and dermatitis had occurred. Rectal and cervical cultures subsequently grew *N. gonorrhoea*, but skin, joint and blood cultures were sterile. The patient was switched to 2 grams of ampicillin orally per day on the sixth day and discharged home. Reculture of rectum and cervix at a later date revealed no residual *N. gonorrhoea*, and at six month follow up she remained asymptomatic without evidence of recurrent articular disease. ◀

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*Editor's Note: This article is the first of a three-part series. The second and third segments will be featured in forthcoming issues.*

# Surgical Grand Rounds

John M. Beal, M.D., Contributing Editor

*Surgical Grand Rounds are held weekly on Tuesday, 5:00 pm in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 22, 1980.*

## Case Report:

## Endometriosis of the Colon

**Dr. Deborah Lange:** The patient, a 47-year-old white woman, stated that she noted blood in her stools associated with cramping and profuse abdominal pain during her monthly menstrual bleeding. Such complaints in a woman of that age might not seem unusual; however she had undergone an abdominal hysterectomy in 1972. Her gynecologic and obstetrical history is significant. In 1964 and 1965 she had live child births by caesarian section. In 1977 and 1978, she had intermittent episodes of vaginal bleeding. In late 1977 she had a biopsy of the vaginal wall and at that time a diagnosis of endometriosis was made. In 1978 she states that "cyst" was removed from the vagina, which was probably another endometrial implant. In late 1979, she again had cyclic vaginal bleeding, this time, associated with the gastrointestinal symptoms. Her physical exam was unremarkable with the exception of pelvic examination which revealed a small mass on the right side which was just above the vaginal vault. There was old blood at the apex of the vaginal vault on speculum examination. Because of the history of these findings, a barium enema was performed.

**Radiology:** A barium enema examination was performed. There is a short segment of marked

narrowing of the lumen of the sigmoid colon (Figure 1). The lesion appears to be extra-mucosal and does not obstruct the lumen. It is eccentric in its involvement of this portion of the bowel. There were no other areas of abnormality on the barium enema. On the basis of radiographic findings, primary adenocarcinoma seems unlikely because the mucosa is not involved and the lesion does not encircle the bowel. The differential diagnosis includes endometriosis, an abscess secondary to diverticular rupture, non mucosal tumors of the colon such as leiomyoma.

**Dr. Deborah Lange:** After the barium enema study, colonoscopy was performed. The scope was passed to 43cms where obstruction was encountered. Patient was admitted to the hospital and, after bowel preparation, operation was performed. What appeared to be an extrinsic benign lesion of the sigmoid colon was found and a partial colectomy was performed. The right ovary, which appeared to contain endometriosis, was also resected. The left ovary could not be found, and was thought to have been removed at the time of the abdominal hysterectomy. The mesentery of the sigmoid colon contained a cystic structure in the leaves of the mesentery which appeared to have the same chocolate-type of fluid. The patient's post operative course was unre-



markable.

**Dr. Denise Hidvegi:** Histologic study demonstrated that the lesion was covered by normal mucosa endometriosis involving the bowel. (Figure 2). In the submucosa and muscular layer, there were well delineated benign endometrial glands surrounded by endometrial stroma. The same type of lesions were present in biopsies obtained from the vaginal wall and in sections of the right ovary. (Figure 3)

**Dr. John M. Beal:** What about the mesentery of the sigmoid? Did that contain endometriosis?

**Dr. Denise Hidvegi:** No other lesions were observed grossly on the serosal surface. However, it is possible that very small lesions could be present, not detectable by naked eye.

**Dr. Deborah Lange:** Endometriosis is "the presence of functioning endometrial tissue, both gland and stroma, outside its normal location."<sup>1</sup> Obviously, the potential for this disease has always existed; however, as far as medical history, it is a relatively new disease.

#### Review of the Literature

It was not until 1860 that von Rokitsky first described the lesion. Not until 1909, did Mackenrodt perform the first partial colectomy secondary to endometriosis, but this diagnosis was not made at the time of operation. This was done in retrospect, reviewing a photograph of the lesion. It was not until 1921 that Sampson first began his extensive publications concerning this disease. At the time his paper was published there were only 20 reports in the literature. Sampson, one of the leaders in this area of research, first postulated one of the still recognized theories of endometriosis histogenesis. The implantation theory states that fragments of endometrium are regurgitated with menstrual bleeding in a retrograde fashion through the oviducts with subsequent implantation on the ovaries or into the posterior cul-de-sac or other peritoneal sites.

Reviewing the intervening literature produces an incidence of 8—15% as the number of women who will have endometriosis during their menstrual life.<sup>2,4</sup> It should be mentioned that the disease may not be manifest until the post-menstrual years if symptoms are secondary to the fibrotic reaction to the implants themselves. This fibrosis will not regress with postmenopausal hormonal changes.

The incidence of intestinal endometriosis is harder to determine. The results of several large series are as follows: 3-34% Meyers *et al.*, (Duke University);<sup>5</sup> 18.3% Colcock (Lahey Clinic);<sup>6</sup> 38% Williams *et al.*, (Mayo Clinic).<sup>7</sup> The area

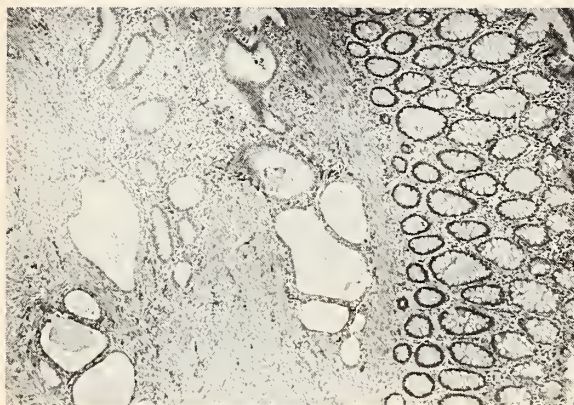


Figure 1

Barium enema demonstrates a filling defect in the sigmoid colon which is compatible with an extramucosal lesion.

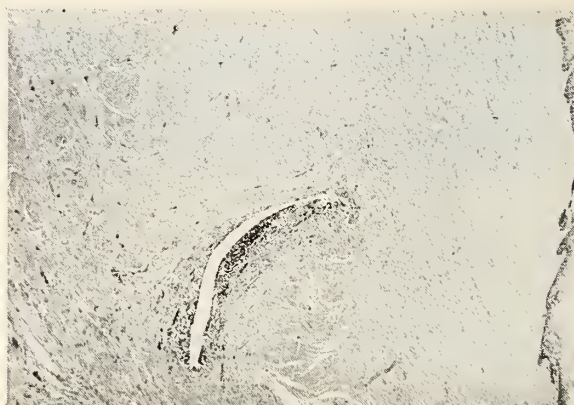
of the intestine most frequently involved is the sigmoid and rectum. This is in contradistinction to earlier papers which stated that the cecum or ileum were most frequently involved.

The symptoms of intestinal endometriosis are: cyclic diarrhea or constipation; pelvic or rectal pains; tenesmus, obstructive symptoms and (rarely) rectal bleeding. Rectal bleeding is uncommon because this lesion is generally submucosal without ulceration. There is evidence that obstructive symptoms may be more common than previously believed. For example, in the series from the Lahey Clinic, although the total incidence of intestinal endometriosis was only 18.3%, the percentage of low grade obstructive symptoms was 36%. In 1943, Jenkinson and Brown<sup>8</sup> reported a series of 117 cases of endometriosis, 46 of which involved the colon and of the 46, 21 had obstructive symptoms; in other words, 45% of their patients. Other symptoms are dyspareunia, infertility and menorrhagia. These are symptoms of endometriosis *per se*, and not of intestinal endometriosis. They are mentioned here as a means of reiterating that the diagnosis of intestinal endometriosis involves a gynecologic history consistent with endometriosis, plus a history of bowel complaints, in a woman of the appropri-



**Figure 2**

Photomicrograph of the endometrioma of the bowel shows the lesion, which is covered by normal mucosa.



**Figure 3**

Vaginal biopsy demonstrates benign endometrial glands in the vaginal wall.

ate age group. The physical examination is usually within normal limits with the exception of possible pelvic findings. There are two chief pelvic findings: a pelvic mass; and nodularity of the uterosacral ligaments or of the cul-de-sac. Sigmoidoscopy will not exclude a diagnosis of the endometriosis since the endometrioma is submucosal and usually will not show up on the biopsy.

### Radiology

Its primary radiologic findings tend to be consistent with, but are not diagnostic of, endometriosis. The location is generally rectal or sigmoid. The lesion itself can either present as a stricture (as it did in this case) or a filling defect. The mucosa is generally intact; but it tends to be irregular. This is secondary to the desmoplastic response to the implant.

Treatment of the disease follows a principle established in 1949 by Counsellor<sup>9</sup> when he stated that treatment was that of the primary disease endometriosis. "If the bowel is not obstructed, the lesions on the bowel will regress with complete removal of the ovarian tissue." He presented several cases with radiologic follow-up which showed marked repression of the colon lesions after oophorectomy. There are two exceptions to this principle of treating only the primary disease. The first is obstructive symptoms. Most of these symptoms are secondary to the marked fibroplasia and desmoplastic response and this tissue will not regress with hormonal manipulation. Therefore, when the presenting symptoms are obstructive, the lesion itself should be removed, in addition to the treatment of the primary disease. The second exception

is when any suspicion of carcinoma is present. This is particularly true in those cases where the mucosa is irregular; there is a large filling defect.

In summary, endometrial involvement in the intestine is an uncommon disease. However, it is a diagnosis that should be entertained in any woman of childbearing age who has both a gynecologic history consistent with endometriosis and cyclic bowel complaints.

**Dr. Michael Govostis:** There is one paper by Williams that was published recently on colonic endometriosis in postmenopausal women. They recommend resection of the colon because hormonal manipulation was unsatisfactory in this period of life. They had a series of seven such cases. There are other theories in addition to Sampsons'—one is the direct adenomyosis theory, direct extension into the uterus muscle. A second one is the growth of arrested remnants of Wolfian bodies. A third is the theory of lymphogenous metastases. Endometriomas about the umbilicus are thought to originate in this manner. Endometriosis of the colon is commonly seen during laparotomy but the implants are often on the serosa and do not cause involvement by obstruction. The endometrioma has to be in the muscular wall and cause constriction of the lumen to produce symptoms.

**Dr. Robert Lane:** This is the first case that I have seen involving a partial obstruction of the descending colon and few in our department have ever seen such a case. Its manner in involving the colon supports Sampsons' implantation theory. However, I have had a case of pure ureters-vesicle endometriosis which supports the



colonic metaplasia theory. The pelvis in this patient contained no endometriosis.

We have learned that endometriosis is no longer a disease of women in their mid-thirties. This is the usual age that textbooks give for first evidence of endometriosis. It is interesting that laparoscopy has revealed endometriosis to be present in the teenager and in the woman in her twenties, whether or not they have symptoms. At the time of laparotomy there is a lack of parallelism between the amount of endometriosis and the symptomatology of the patient. We have seen large endometriomas without any symptoms and we have seen minimal endometriosis with significant symptoms. The last point I wish to make is that, had this patient shown some evidence of endometriosis at her hysterectomy, which was at age 40, she would have been served best by a complete removal of her adnexae as well as her uterus. This would have avoided the current surgery. I think that all of the pelvic organs should be removed for any woman who is in her 40's and comes to laparotomy for endometriosis to avoid any future sequelae of endometriosis. ◀

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## SBS In Action

(Continued from Page 113)

lack of coastline or paucity of Broadway plays. While we do have much to boast about, let us cultivate our assets and fertilize our weaker areas (including residency programs) . . . While what to buy the young doctor for medical school graduation is still a problem, 3/4 won't need that suitcase . . . buy them an Illinois license so they'll want to stay at home. ◀

Michael L. Nieder  
University of Ill. College of Medicine  
Vice-chairman, ISMS/SBS

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# Special Articles

## The 1893 Medical Practice Act

*An interesting historical document, the original handwritten copy of the bill introduced into the General Assembly establishing a new Medical Practice Act in 1893, has been shared with IMJ by Charles Wells, M.D., of Mt. Vernon. Dr. Wells is preserving this valuable item, but felt present-day physicians would be interested in the content.*

*A type-script copy was made and set in print, preserving the actual spellings, punctuation, and verbiage. This is reproduced below.*

### A Bill

*For an act to establish a board of Medical Examiners for the State of Illinois, for the examination of practitioners of Medicine and Surgery and prescribe their duties, and to repeal certain acts herein named.*

*Sec. I. Be it enacted by the people of the State of Illinois represented in the general assembly. That from and after the first day of October, 1893, there shall be a board of Medical Examiners for the State of Illinois whose duties it shall be to examine all persons desiring to practice medicine or surgery in any of their branches within this State.*

*Sec. II. On or before the first day of September 1893. The Illinois State Medical Association shall nominate to the Governor twenty-seven reputable physicians, of which number nine shall be by him selected; and the Illinois Institute of Homeopathy shall nominate to the Governor three reputable physicians, one of whom shall be by him selected and the Eclectic Medical Society, of the State of Illinois shall nominate to the Governor three reputable physicians of*

*whom one shall be selected and the eleven thus selected by the Governor shall constitute the State Board of Medical Examiners. In case of death, resignation removal or from any cause a vacancy occur in this board the society—or Institute that nominated him shall nominate three reputable physicians from whom the Governor shall select his successor, provided that shall such society or institute fail or refuse to make such nominations, within thirty days after notice to do so, by the secretary of this board, then in that event, the Governor shall appoint such physician as he may deem best provided further, that no member of this board shall in any way be connected with any Medical College of this or any other State.*

*Sec. III. Every person who shall be appointed to serve upon this board shall receive a certificate of appointment from the Governor, and shall within 30 days from the date of such certificate, take, subscribe and file in the Office of the Secretary of State the oath provided for in the Constitution of the State of Illinois. The board shall make and adopt all rules, regulations and by laws for their government, not inconsistent with the Constitution and laws of this State or of the United States.*



*Sec. IV. The income of this board as hereinafter provided, after paying all necessary expenses, shall be appointed among its members, pro rata, provided that the Secretary of the board, wheather a member or not, shall receive nothing from its income.*

*Sec. V. The first meeting of the board of medical examiners shall be held, persuant to the call of the Governor, in the city of Springfield, within sixty days of the first day of October 1893, suitable notice thereof having been given to each member by the Secretary of the State. At the first meeting of the board an organization shall be effected by the election of president, who shall be a member of the board and a secretary who may or may not be a member thereof. For the purpose of examining candidates—for license to practice medicine or surgery in any of its branches in this State, this board shall hold two or more stated or special meetings in each year, at such times and places as the board may elect, provided that one such stated meeting shall be held in the City of Springfield. Each member shall be assigned by the Executive Committee one of the following subjects: Anatomy, Physiology, Hygiene, Chemistry, Surgery, Obstetrics including Gynecology, Pathology, Materia Medica and to the Practice of Medicine, provided that one each nominated by the different Societies and the Institute as provided for in this act, shall be assigned to the Practice of Medicine.*

*Sec. VI. Each member assigned as provided for in the foregoing section, shall prepare questions to be propounded to applicants—for license, for the branch to which he has been assigned, and shall conduct, when present, the examination in such branch, and when, for any reason such member is absent, from a meeting when such examinations are made, he shall send such questions as he shall desire to be propounded to applicants, to the Secretary of the board, and the president of the board, shall designate some other members of the board to conduct that part of such examination, using the questions*

*sent by such absent member, provided, that if such absent member has not sent such questions, then the member designated by the president may propound such questions as he may deem best.*

*Sec. VII. All persons who may desire to practice medicine or surgery, in any of their Branches in the State of Illinois, on or after October 1st 1893, who are not at that time qualified practitioners according to law, shall submit to an examination before the State board of Medical Examiners. The board shall examine all applicants for license under this act, and if such persons shall pass a satisfactory examination which may be wholly or in part in writing, and which shall be of an elementary and practical character, but sufficiently strict to thoroughly test the qualifications of the applicants, then said board shall cause to be issued to such applicant, a certificate or license to practice Medicine and Surgery in this State, provided that if such applicant affiliate with the Homeopathic School he shall be examined upon the practice of medicine by the member of the board nominated by the Illinois Institute of Homeopathy, And if he affiliate—with the Eclectic School Medicine, then he shall be examined upon the practice of medicine by the member of the board nominated by the Eclectic Medical Society. —all others to be examined by the members of the board nominated by the Illinois State Medical Association., provided further that any practitioner announcing himself as specially proficient in any special branch of Medicine or Surgery.*

*Shall be cited before this board upon thirty days notice, to pass a special examination in the branch or branches in which he professes special qualifications, and if such practitioners after such notice fails or refuses to appear before the board, for examination, then in that court his certificate or license shall be revoked unless he have a reasonable excuse for such failure. Any practitioner, who goes from place to place about the State claiming special proficiency in chronic or other diseases or injuries shall be in like manner, cited before the board, for like purposes and be subject to like penalties.*

*Sec. VIII. The board at its first regular meeting, shall elect a Secretary who shall receive a salary of eighteen hundred dollars per annum and he shall upon order of the president of the board, issue to each applicant that has passed a satisfactory examination, a certificate or license, signed by each member participating in the examination, and by the president and secretary of the board as such.*

*Sec. IX. The board shall exact a fee of twenty dollars for the examination of an applicant which said fee shall not be returnable provided that for the special examinations provided for in this act a fee of Fifty-dollars shall be exacted that shall not be returnable.*

*Sec. X. The Executive Committee of the State board of Medical Examiners shall have the general supervision of the health of the people of the state. They shall have charge of all matters pertaining to quarantine and shall make such sanitary investigations as they may deem necessary, for the preservation of the public health. And it shall be the duty of all police Officers, Sheriffs Constables and other employees of the State to enforce such rules and regulations as this committee shall make.*

*Sec. XI. It shall be the duty of all practitioners of medicine or surgery in any of its branches within this state to register their names and Post Office address with the County Clerk of their respective counties, and in such other counties in which they may practice their profession and they shall report within thirty-days of the event, all births and deaths that may occur under their supervision, and the cause of death, and such other facts as the Executive Committee of the State board of Medical Examiners may require, in a blank form to be furnished by the State board of Medical Examiners to County Clerks and they to practitioners, provided that said practitioners shall be paid a fee of twenty-five cents, each for such reports, which said sum shall be paid out of the county*

*treasury upon the Certificate of the County Clerk.*

*Sec. XII. It shall be the duty of every person engaged in the practice of medicine or surgery in any of its branches, to name, subscribe and deliver to the assessor or deputy assessor of his County, or township, at the time of making the annual assessments of property, an affidavit to be sworn to before such assessor or deputy assessor, or other person authorized to administer Oaths, which affidavit shall state whether or not, such practitioners has made report of all births and deaths occurring under his supervision during the year just passed, as provided for in section eleven of this act. Suitable blanks for this purpose shall be furnished by the State board of Medical Examiners, to the several County Clerks in this State, and by them to the several assessors within their respective counties, provided that this section of this act shall not be in force until one year after the taking of effect of this act.*

*Sec. XIII. Any violation of any of the provisions of this act no herein before provided for shall subject the offender to a fine of not less than ten nor more than two hundred dollars.*

*Sec. XIV. The sum of two thousand dollars per annum, for two years is hereby appropriated to pay for the blanks provided for in this act, and for their distribution.*

*Sec. XV. An act entitled an act to regulate the practice of medicine in the state of Illinois approved May 29th 1877, In force July 1st 1877 and an act entitled an act to create and establish a Board of health in the State of Illinois approved May 25th 1877 in force July 1st 1877, and all other acts and parts of acts in conflict herewith, are hereby repealed.*

*Sec. XVI. The Secretary of State shall provide rooms suitable for the meetings of this board, and office rooms for its secretary.*



# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

### NOTICE OF SPECIAL IMPAC MEETING

The Illinois Medical Political Action Committee will meet in special session in conjunction with the ISMS Interim Meeting, scheduled for October 25-26, 1980 in Peoria, Illinois to consider changes in the IMPAC Constitution and Bylaws necessitated by recent rulings by the Federal Election Commission. That meeting is scheduled as follows:

Saturday, October 25, 1980

Immediately following the adjournment of the House of Delegates  
Shrine Temple (located across the street from the Continental Regency Hotel)  
Peoria, Illinois.

All IMPAC members are encouraged to attend. The changes in the Constitution are as follows:

PREAMBLE: We members of the medical profession, ~~our wives and associates~~ do hereby band together to exert our collective influence for better government through political action and education.

ARTICLE I - NAME: The name of this organization shall be the Illinois State Medical Society Political Action Committee, hereinafter referred to as IMPAC.

ARTICLE V - MEMBERSHIP: There shall be three (3) classes of membership in IMPAC, ~~viz: Regular, Sustaining and Special, as hereinafter defined.~~ All such classes shall be entitled to those benefits as enumerated in Article VI.

~~Section 2:~~ a) Regular Membership. Any Doctor of Medicine who is a member in good standing of his county and state medical society, ~~and his or her spouse,~~ may become a regular member upon payment of dues.

b) Member. Any individual who pays dues voluntarily to IMPAC may become a member.

~~bc)~~ Sustaining Membership. ~~Any Doctor of Medicine who is a member in good standing of his county and state medical society, and his or her spouse, may become a sustaining member.~~ Any individual meeting the criteria of Sections 1a and 1b may become a sustaining member upon payment of dues.

~~c) Special Membership. One or more categories of special membership may be established by the Council under terms and conditions specified by the Council.~~

ARTICLE VIII - OFFICERS AND EXECUTIVE COMMITTEE OF THE COUNCIL: Section 6, c) The Secretary-Treasurer shall be the custodian of all the funds and official records of IMPAC. He shall cause all funds to be deposited and/or invested and all records to be kept in accordance with directives of the Council. He shall disburse the funds of IMPAC in the manner authorized by the Council subject to any applicable provision of the law with respect thereto. He shall present a report at the annual meeting, meetings of the Council, and at such other times as requested by the Council or Executive Committee. He shall prepare, sign, and file all reports required of IMPAC by law.

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

# Membership Forum

*Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The Editors cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.*

*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

## **Government Complaints Should Be Itemized**

Editor

Recently, I completed a Medicare form for an elderly patient on Public Aid for an office visit. In a few weeks the form was returned after careful evaluation by a brainy computer with pages of explanation that they do not pay. However, if I attach this form to a properly completed Public Aid form, I might collect. Eventually I was paid. I estimate that the processing of this claim cost Medicare-Public Aid about \$12-15.00. A single private carrier could handle this 30-40% cheaper. We should have a law that: (1) if a private carrier can handle a claim cheaper, the task should be assigned to the private company; and (2) multiple insurance carriers should be eliminated. They only multiply the administrative cost. If we would have such policy, we could lower the administrative cost immediately and substantially. When the government complains about the cost of health care, it should itemize:

Services rendered	\$100.00
Medical cost	60.00
Administrative cost	40.00

Such a cost analysis would improve the image of the medical profession in the eyes of the public.

James Scott, M.D.  
Streator

## **Retired Member's Update**

To the Editor:

Several years ago, I wrote you about Costa Rica and our planned retirement there (my husband is retired Navy). You asked that I write again, when settled, but I have been so busy living I haven't had the time!

However, today, listening to the news . . . gloom, wars, energy crises, the shrinking dollar and poor Jimmy Carter . . . it occurred to me your readers might enjoy the second episode in the "Saga of the Birds."

We moved, bag, baggage, grandmother, teenagers and all, to Costa Rica three years ago and have been happily settled in Ranchos Maricosta. Our experiences deserve a book. They have not only been exciting but, at times, hilarious. The only flaw was our inability to find easily-accessible, registered beach property. Probably a blessing in disguise. It made us look to Colombia (another

democratic republic, where, it turned out, it cost even less to live than Costa Rica).

There we found Palmas de Oro, a lovely, old coconut plantation on the Caribbean. And, to complete its unique setting, when we looked away from the sea we saw, towering over everything, 19,000 feet high and snow-capped, majestic Mount Columbus of the Sierra Nevadas.

It may be hard to believe . . . hundreds of green palms, blue sky and ocean, pounding surf and golden sand, snow-capped mountains . . . but it is all there in Palmas de Oro; on the Pan American Highway near Santa Marta, oldest and most fascinating city in all of the Americas.

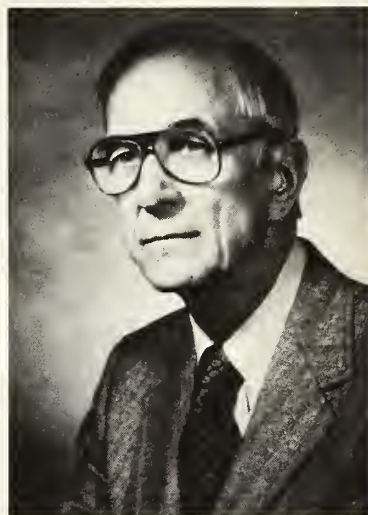
So, now we have two loves: our ranch in Costa Rica and beach in Colombia. We feel we have discovered a new, exciting American frontier and are eager to share our find with others. (If you think you are too old for adventure, we are 59 and 63 and both of us have battled and, so far, conquered cancer!) Write us at P.O. Box 157, Liberia, Guanacaste, Costa Rica and send your letters by international air mail (31¢ per half-ounce). We promise to answer.

Now, from Latin America, we wish you salud (health), dinero (wealth) and amor (love)!

JUANITA BIRD  
(Mrs. Lewis M. Bird)



# President's Page



## *An Idea for the 80's*

## **Ethics = Morals = Individual Application**

Historically, the medical profession has defined and refined its ethical guidelines more clearly than any other profession.

2500 B.C.	Code of Hammurabi detailed appropriate conduct for physicians.
5th Century B.C.	Oath of Hippocrates made a concise statement protecting the rights of patients and appealing to the just instincts of physicians.
1803	Thomas Percival authored the first detailed codification of medical ethics.
1847	American Medical Association adopted Percival's code as a standard for American medicine.
1903	Revision
1912	Revision
1947	Revision
1958	The Principles of Medical Ethics were reduced to a preamble and ten sections which addressed major concerns of that period.

The 1980 revision of the Principles of Medical Ethics consists of clean, broad patient-oriented statements which also recognize the inherent integrity of the physician. The revision's strength rests in the affirmation of the patient's primacy, when not contrary to law, and the dedication required of the physician.

Our profession has clearly demonstrated its commitment to the patient by responding to a changing society. ◀

A handwritten signature in cursive script that reads "Herschel Browns, M.D." with a small arrow pointing to the right at the end.

Herschel Browns, M.D., President ◀

# Illinois Society, American Association of Medical Assistants

## ***Professionally Speaking, Doctor When Was the Last Time You Really Looked At Your Medical Assistant?***

BY MARYGRACE SANDERSON  
COOK COUNTY SOUTH CHAPTER

If your medical assistant is a "Perfect 10" don't bother to read any further. If you are a physician associated in a large or small clinic group you may employ a business manager who hires the professional people who work for you. Please direct this article to that person. I am primarily addressing my remarks to those physicians who employ one or two but less than ten medical assistants.

Doctor, I am aware of the fact that you have trained your personnel in the clinical aspect of your office and I am reasonably sure that your medical assistant knows her job responsibilities. My question is: Are you spending more time in the office and enjoying it less? Are you really satisfied with your medical assistant's job performance? Is your medical assistant as knowledgeable as she should be about good office practices or credit and collection procedures? What about your Medicare and Medicaid receivables, are they under control? Is your cash flow as good as it should be? If you have answered *no* to one or more of the above questions, *consider what membership in the American Association of Medical Assistants can do for your staff.*

The Illinois Society, AAMA, can make the difference. Our organization is dedicated to improving medical assistants educationally and professionally. We can help your staff develop their

skill. Courses in anatomy and medical terminology, physiology, professional law and ethics are taught by professionals with excellent qualifications and credentials. Our Medicare and Medicaid workshops, personal development seminars, and lectures by your physician colleagues at our monthly meetings can and will make a difference in your office climate.

Encourage your medical assistant to invest in her future. Don't accept the excuse that she "doesn't have the time," or that, "her family responsibilities are too great." (Her husband and children will cooperate and she can manage her time.) Doctor, you have invested a great deal of time and money developing your own career and practice. Consider paying the dues in our professional organization as a bonus or fringe benefit, or just as an incentive to bring her thinking to a different perspective.

If a professional career is what your medical assistant is looking for, and excellence is what you are looking for, I am offering you the solution. Membership in the Illinois Society, AAMA, is the best investment either of you will ever make.

For further information, contact Elaine Kaiser, CMA-A, 9103 Sandpiper Court, Orland Park, Illinois 60462 or Marygrace Sanderson, 501 Heathermead Road, Matteson, Illinois 60443. ◀



# Doctor's News

**RESOLUTIONS REMINDER**—The ISMS House of Delegates Interim Session will convene October 25-26 at the Continental Regency Hotel, Peoria. Resolutions proposed for consideration at the Interim Session must be received in the ISMS offices no later than September 27, 1980. Those received at a later date will be considered late resolutions and require special consideration for inclusion at the Interim Session. A complete program for the Interim Session will be published in the October *IMJ*.

**FDA ISSUES WARNING**—The Food and Drug Administration has issued a warning to patients taking the prescription diuretic furosemide that three manufacturers have illegally marketed tablets that may be ineffective and therefore harmful to patients who need the drug. FDA advises patients taking furosemide to be sure that the name Hoechst is on the tablets. Hoechst, the only manufacturer with FDA approval to market furosemide, sells it under the trade name Lasix. FDA advises that patients taking furosemide tablets that do not have the Hoechst name on them should ask their pharmacist for a replacement. FDA has further advised that no other diuretics but furosemide are involved in this action. The action affects only tablets of furosemide; other dosage forms are not affected.

**CONTROLLED SUBSTANCE LICENSES**—State of Illinois controlled substance licenses should have been renewed by physicians by September 5, 1980. Those who did not receive the renewal form should immediately contact the Illinois Department of Registration and Education, 320 W. Washington, Springfield, IL 62786. The annual cost of license renewal is \$5.00.

**DRUG APPROVAL UPDATE**—The Food and Drug Administration has approved a new drug, ritodrine hydrochloride, for use in stopping premature labor. The drug acts by relaxing the uterus and may help to prevent premature births—and associated health risks to infants born before 36 weeks gestation. European and U.S. studies of this drug among women more than 20 weeks pregnant have supported the drug's safety. Ritodrine is not intended for pregnancies less than 20 weeks. FDA further reports that side effects found in clinical trials include increased maternal and fetal heart rate, palpitations, tremor, nervousness and a mild drop in blood pressure.

**CHILD ABUSE CONFERENCE ANNOUNCED**—The Illinois Chapter for the Prevention of Child Abuse will sponsor their third annual governor's conference on prevention, "Focus: The Family," September 25-26 at the Conrad Hilton Hotel in Chicago. Registration for non-ICPCA members is \$62.00. Further information and registration may be obtained by writing the Third Annual Governor's Conference, Suite 1250, 332 S. Michigan Avenue, Chicago IL 60604.

**IMMUNIZATION REMINDER**—Illinois school children may be denied admission to classes this month if they have not been immunized against polio, diphtheria, tetanus, whooping cough, measles and rubella and also had a physical examination. The only exceptions are those for medical or religious reasons, verified by the attending physician or, in the latter case, by a written and signed parental statement detailing religious objection. Further information on immunization is detailed on page 123 of this month's *IMJ*.

**ISMS TRAVEL UPDATE**—The first item in the 1981 travel schedule is a January 28-February 12, 1981, trip to South Africa. Reservations for ISMS-sponsored travel programs must be submitted on the official form printed in promotional brochures which are mailed to all ISMS & Auxiliary members. Further information may be obtained through the ISMS offices.

**"MESSAGE TO MY PATIENTS,"** is the title of a free brochure available from the National Highway Traffic Safety Administration. The pamphlet documents motor vehicle incidents as the leading cause of death for Americans under the age of 35. Up to 50 copies of the brochure, which was prepared in collaboration with the AMA, may be obtained by writing: NHTSA General Services Division, 400-7th Street SW, Washington, D.C., 20590.

**SPORTS MEDICINE LECTURE SERIES**—The Northwestern University Medical School, Center for Sports Medicine, will sponsor a series of lectures at 7:00 Wednesday evenings beginning October 1, 1980. Further information may be obtained by writing the Northwestern University Medical School, Center for Sports Medicine, 303 E. Chicago Avenue, Room 2-063, Chicago, IL 60611; (312) 649-7959.

**PHYSICIANS IN THE NEWS**—**D. Dax Taylor, M.D.**, Springfield, has been named vice president for evaluation programs of the National Board of Medical Examiners. An executive associate dean and professor of pathology at the SIU School of Medicine, Dr. Taylor has served as a member of the ISMS Committee on CME Accreditation.

**Alexander M. Schmidt, M.D.**, Chicago, has been named vice president for academic affairs at the UI Medical Center. A former commissioner of the FDA, he will continue to serve the university as a professor of medicine and pharmacy practice. . . **Morgan M. Meyer, M.D.**, Lombard, has been named to the AMA accrediting body for continuing medical education—CACME. Dr. Meyer, long a member of the ISMS delegation to the AMA, was appointed by the AMA Board of Trustees.

A guest article by **Joseph H. Skom, M.D.**, former ISMS president and a member of the DEA/Practitioners Working Committee, is featured in the current issue of *Registrant Facts*. Dr. Skom's article gives expert advice on prescribing considerations. *Registrant Facts* is a biannual publication of the Drug Enforcement Administration.

**B. Smith Hopkins, M.D.**, Champaign, has been appointed executive director of the State Health Coordinating Council . . . Dr. Hopkins is former ISMS Health Planning Committee chairman.

**Robert J. Stein, M.D.**, Chicago, was recently given the 1980 Superior Public Service Award for his service as Cook County Medical Examiner. The award cites him as the outstanding executive employee of the county. Dr. Stein was also commended by the Illinois House of Representatives. . . . A Distinguished Service Award was recently initiated by the Illinois Society of Physical Medicine and Rehabilitation. The award was established to honor **Dr. Louis B. Newman's** pre-eminence in rehabilitation medicine.

**NEW PUBLICATION AVAILABLE**—*Hospital Risk Management* is a new monthly newsletter which presents current news in hospital-based risk management programs, legal trends and legislative reforms. Subscriptions are available at \$86 per year from Hospital Risk Management, Suite 118-H2, 67 Peachtree Park Dr., Atlanta GA 30309.



## Family Medicine

### Management of the Acute Cardiac Patient

For: FP's. Lecture, Nov. 5, Chicago. **Speaker:** Kenneth Rosen, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$200. **Reg. Limit:** 75. **Credit:** Category 1, 21 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Medicine

### Clinical Allergy for the Practicing Physician

For: MD's. Lectures/workshops, Nov. 6-8, St. Louis, MO. **Sponsor:** Washington University School of Medicine, CME, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$160. **Reg. Limit:** 150. **Credit:** Category 1, 17 1/2 hours; AAFP Prescribed, 17 1/2 hours; AOA, 17 1/2 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/367-9673.

## Infectious Diseases

### Respiratory Viral Infections

For: MD's. Lecture, Nov. 12, 2:00 p.m., Rockford. **Speaker:** George Jackson, MD. **Sponsor:** Div. of Infectious Diseases, Rockford School of Medicine, University of Illinois College of Medicine. **Fee:** \$10. **Credit:** Category 1, 2 hours. **Contact:** Office of CME. **Phone:** 815/987-7140.

## General Medicine

### Recent Advances in Diagnosis and Management of Cardiac Arrhythmias

For: MD's. Course, Nov. 12, Brookfield, WI. **Sponsor:** The Medical College of Wisconsin, 8701 Watertown Plank Rd., Milwaukee, WI 53226. **Fee:** yes. **Reg. Limit:** none. **Contact:** Willard Duff.

## Geriatrics

### Aging and Illness in Primary Care

For: MD's. Lecture, Nov. 5-7, Madison, WI. **Sponsor:** CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53708. **Fee:** \$215. **Credit:** Category 1, 21 hours; AAFP. **Contact:** Sarah Aslakson. **Phone:** 808/263-2850.

## Medicine

### Advances in Internal Medicine

For: Internists. Lecture, Nov. 10, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$300. **Reg. Limit:** 100. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Pathology

### A Practical Approach to Diagnostic Hematologic Problems

For: Pathologists, Hematologists, residents in pathology Workshop, Nov. 10-14, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago 60612. **Fee:** yes. **Reg. Limit:** 50. **Credit:** Category 1, 30 hours. **Contact:** Administrative Assistant, Educational Center Programs.

## Psychiatry

### Transference in Psychoanalytic Psychotherapy

For: Psychiatrists, Psychologists. Course, Nov. 1-2, Sheraton Plaza Hotel, Chicago. **Sponsor:** The Chicago Institute for Psychoanalysis, 180 N. Michigan Ave., Chicago 80801. **Fee:** \$150. **Reg. Limit:** none. **Credit:** Category 1, 10 hours. **Contact:** Richard Telingator, MD. **Phone:** 312/332-2448.

## Pulmonary

### Pediatric Pulmonary Conference

For: MD's. Course, Nov. 19, Chicago. **Sponsor:** Chicago Lung Association, 1440 W. Washington, Chicago 60607. **Course Director:** Dharmapuri Vidyasagar, MD. **Phone:** 312/243-2000.

## Respiratory

### Acute Respiratory Failure—Admissions to Discharge

For: MD's. Workshops, Nov. 8-8, The Inn on the Park, Madison, WI. **Sponsor:** CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53708. **Fee:** \$150, MD; \$100, RN, resident. **Credit:** Category 1, 15 hours; 15, CEU. **Contact:** Sarah Aslakson. **Phone:** 608/263-2850.

## Surgery

### Workshop on the Use of Staples in Surgery

For: Surgeons. Workshop, Nov. 14, 8:00 a.m., St. Louis, MO. **Sponsor:** Dept. of Surgery, St. Louis University Medical Center, 1402 S. Grand Blvd., St. Louis, MO 63104. **Co-sponsor:** Autosutures, Inc. **Fee:** \$200. **Reg. deadline:** 11/7. **Reg. Limit:** 10. **Credit:** Category 1, 7 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 x 127.

## Surgery

### Flexible Fiberoptic Sigmoidoscopy

For: Surgeons. Lecture, Nov. 15, Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$100. **Reg. Limit:** 60. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

# DECEMBER

## Dermatology

### Symposium on Dermatology

For: MD's. Symposium, Dec. 5, 12 and 19, 11:15 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. **Fee:** none. **Reg. Limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

## General Medicine

### Financial Strategies for Health Professionals

For: MD's. Course, Dec. 6, Marriott Hotel, Milwaukee, WI. **Sponsor:** The Medical College of Wisconsin, 8701 Watertown Plank Rd., Milwaukee, WI 53226. **Fee:** yes. **Contact:** Willard Duff.

## General Medicine

### Medical Malpractice

For: MD's. Symposium, Dec. 11, 7:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. Limit:** none. **Fee:** \$25. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## General Medicine

### Oncology—Overview

For: MD's. Symposium, Dec. 6, 1:00 p.m., Robinson. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. Limit:** none. **Fee:** \$25. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## General Medicine

### Eye, Ear, Nose and Throat

For: MD's. Symposium, Dec. 4, 1:00 p.m., Red Bud. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. Limit:** none. **Fee:** \$25. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## General Medicine

### Nutrition and Clinical Medicine

For: MD's. Symposium, Dec. 4, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. Limit:** none. **Fee:** \$25. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## General Medicine

### Orthopedics

For: MD's. Symposium, Dec. 3, 6:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. Limit:** none. **Fee:** \$25. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## General Medicine

### Urinary Tract Infections

For: MD's. Symposium, Dec. 3, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. Limit:** none. **Fee:** \$25. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Infectious Diseases

### Practical Immunology for the Clinician

For: MD's. Lecture, Dec. 10, 2:00 p.m., Rockford. **Speaker:** Joseph Silva, MD. **Sponsor:** Div. of Infectious Diseases, Rockford School of Medicine, University of Illinois College of Medicine. **Fee:** \$10. **Credit:** Category 1, 2 hours. **Contact:** Office of CME. **Phone:** 815/987-7140.

## Infectious Diseases

### Infectious Disease Conference

For: MD's. Lecture, 5th Tuesday of month, 8:30 a.m., Melrose Park. **Sponsor:** Westlake Community Hospital, 1225 Superior St., Melrose Park 60160. **Fee:** none. **Reg. Limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Frank Sedlak, MD. **Phone:** 312/681-3000 x 210.

## Internal Medicine

### Selected Topics in Medicine, Radiology and Surgery

For: MD's. Lecture, Dec. 6-7, St. Louis, MO. **Sponsor:** Washington University School of Medicine, CME, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$150. **Reg. Limit:** 200. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/367-9673.

## Neurology

### Neurology for the Non-Neurologist

For: GP's, FP's, Internists, Psychiatrists. Symposium, Dec. 10-12, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Fee:** \$275. **Reg. Limit:** 150. **Credit:** Category 1, 20 hours. **Contact:** Kathy Mulherin-Carroll. **Phone:** 312/942-7119.

## Primary Care

### EKG Interpretation and Arrhythmic Management

For: GP's. Lectures/workshops, Dec. 5-6, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. **Fee:** \$245, MD; \$130, technician. **Reg. Limit:** 60. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Stephen Mattingly. **Phone:** 800-525-8646 x 237.

## Reconstructive Surgery

### Hand Surgery Update—1980

For: Surgeons. Symposium, Dec. 4-5, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Fee:** \$225. **Reg. Limit:** 200. **Credit:** Category 1, 13 hours. **Contact:** Kathy Mulherin-Carroll. **Phone:** 312/942-7119.

## PULLING IT ALL TOGETHER

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Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603

# Viewbox

(Continued from page 107)

## DIAGNOSIS: ACUTE PYELONEPHRITIS

The urographic changes of acute pyelonephritis may mimic all of the choices given. If clinical and laboratory data suggest possible vascular disease, obstruction, or neoplasm, further studies are needed. These two patients had positive urine cultures and responded promptly to antibiotics.

The diagnosis and treatment of acute pyelonephritis in the adult usually poses no difficulty and radiographic studies are not done. There has been widespread belief that few, if any, abnormalities are found on intravenous urography (IVU) in patients with acute infection. Textbooks and literature in the United States prior to 1971 state that the IVU is useful in excluding underlying lesions predisposing to infection but urographic findings caused by acute pyelonephritis are not described.<sup>1</sup>

An intravenous urogram may be obtained in a patient with acute pyelonephritis when clinical data or failure of expected response to therapy suggest an underlying obstruction, urinary tract anomaly, or occult calculus and also in patients with an atypical presentation.

In two reported series totaling 81 patients with acute pyelonephritis who were examined with intravenous urography, 20 (25%) had abnormalities.<sup>2,3</sup> This incidence is probably high since many of these patients had severe or atypical disease as an indication for an IVU.

Abnormalities found on IVU usually involve a whole kidney but may be segmental or bilateral. Findings described in 50 reported cases reviewed are listed in order of frequency:<sup>1-9</sup>

- |                                      |                        |
|--------------------------------------|------------------------|
| (1) Enlarged kidney                  | 37 (Fig. 2)            |
| (2) Faint nephrogram                 | 22 (Fig. 1)            |
| (3) Faint collecting system          | 22                     |
| (4) Effaced (thinned) calyces        | 18 (Fig. 1,2)          |
| (5) Delayed opacification of calyces | 17                     |
| (6) Non-opacified collecting system  | 10 (Fig. 1—lower pole) |
| (7) Dilated calyces                  | 9                      |
| (8) Dilated ureter                   | 6 (Fig. 2)             |

The most common urographic presentation is an enlarged kidney with a faint nephrogram, de-

creased density of collecting system opacification, and decreased volume of the calyceal system (effaced calyces). This radiographic appearance may also be seen with acute renal vein thrombosis. If renal vein thrombosis is a possibility on clinical grounds, renal venography can be used to differentiate the two.<sup>1,2,4</sup>

A less common urographic presentation is a large kidney with a faint nephrogram and no opacification of the collecting system.<sup>5,6</sup> Acute ureteral obstruction is a common cause of non-opacification of the collecting system but obstruction causes progressive increased density of the nephrogram rather than the faint nephrogram often seen in acute pyelonephritis. If there is doubt concerning obstruction, this must be resolved since the effect of acute infection in an obstructed system is catastrophic. Ultrasound is the method of choice to rule out obstructive hydronephrosis.<sup>7</sup> (The collecting system would not be dilated in acute pyelonephritis.) Only in exceptional cases would a retrograde pyelogram be necessary. In a patient with clinical grounds to suspect acute renal artery occlusion, a renal arteriogram would be needed, since acute arterial occlusion can produce a large kidney with a faint nephrogram and a non-opacified collecting system identical to acute pyelonephritis.<sup>1,5,6</sup>

Another less common presentation of acute pyelonephritis on urography is non-obstructive hydronephrosis. Again if there is serious doubt concerning ureteral obstruction, it must be resolved and may require retrograde pyelography in this case.<sup>2,8</sup>

Patients with acute pyelonephritis have been reported with a urographic appearance simulating diffuse or focal neoplasms<sup>5,6,9</sup> and in these problem cases follow-up urography, ultrasound, computed tomography or angiography may be needed.

The urographic findings in adults with acute pyelonephritis are due to a combination of edema, vascular redistribution in the swollen kidney confined by its tight capsule, and the effects of endotoxin produced by bacteria.<sup>4</sup>

The classic radiographic appearance of chronic pyelonephritis (multiple focal cortical scars with blunted underlying calyces) is almost always the result of childhood infections. Acute pyelonephritis in adults, even with repeated bouts of infection, seldom causes permanent damage detectable on urograms. The abnormal urogram of acute pyelonephritis reverts to normal, often within weeks. Exceptions to this are infrequent cases of permanent scarring following adult acute pyelonephritis when there is accompanying ob-



struction or reflux and in some cases of severe infection occurring in diabetics.<sup>5</sup> ◀

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## Vice President-Medical Affairs

Ravenswood Hospital Medical Center, a 450 bed teaching institution, is seeking candidates for the position of Vice President, Medical Affairs. The Medical Center is located on Chicago's north side and is affiliated with the University of Illinois College of Medicine. The candidate must be a medical doctor with demonstrated medical administration experience, preferably in a teaching institution. The Vice President, Medical Affairs has administrative responsibility for six clinical departments, selected medical service departments, and the Department of Medical Education. He/she reports to the president of the corporation, is a member of the medical board, and attends all board of directors meetings. The Vice President, Medical Affairs is geographic, full time, with competitive compensation and benefits. Please send your curriculum vitae to:

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## Clinics for Crippled Children Listed for October

Thirty-seven clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 26 general clinics, 10 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Hinsdale—Hinsdale Sanitarium
- 2 Sterling—Community General Hospital
- 2 Lake County Cardiac—Victory Memorial
- 3 Division Cardiac—U. of I. at the Medical Center
- 7 Park Ridge Cardiac (a.m.)—Lutheran General Hospital
- 7 Park Ridge General (p.m.)—Lutheran General Hospital
- 7 Wheaton General—Marianjoy Rehab. Hospital
- 7 Danville—Lake View Hospital
- 7 Maryville—Oliver C. Anderson Hospital
- 7 Quincy—Blessing Hospital
- 8 Joliet—St. Joseph's Hospital
- 8 Champaign—Urbana—McKinley Hospital
- 8 Cairo—Southern Seven Health Department
- 9 Aurora Cardiac—Mercy Center for Health Care Services
- 9 Springfield General—St. John's Hospital
- 9 Kankakee General—St. Mary's Hospital
- 13 Chicago Heights Cardiac—St. James Hospital
- 13 Peoria Cardiac—St. Francis Hospital
- 14 East St. Louis—Community Hospital
- 14 Peoria General—St. Francis Hospital
- 15 Chicago Heights General—St. James Hospital
- 15 Aurora General—Mercy Center for Health Care Services
- 15 Mt. Vernon—Good Samaritan Hospital
- 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 16 Rockford—St. Anthony's Hospital
- 16 Bloomington—Mennonite Hospital
- 17 Kankakee Cardiac—St. Mary's Hospital
- 20 Peoria Cardiac—St. Francis Hospital
- 20 Chicago Heights Cardiac—St. James Hospital
- 21 Maywood—Loyola Medical Center
- 21 Evanston—St. Francis Hospital
- 21 Belleville—St. Elizabeth's Hospital
- 21 Rock Island Area General—Moline Public Hospital
- 21 Decatur—Decatur Memorial Hospital
- 21 Elgin MM—Sherman Hospital
- 22 Springfield Ped-Neuro-St. John's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## Health Care In the '80s

**A one-day symposium,  
October 23, 1980.**

**Continental Regency Hotel,  
Peoria**

This meeting will provide a forum to hear and discuss the positions of ISMS, the Illinois Hospital Association, and associations of Allied Health Professionals, as to the role each professional plays in providing personal health care services.

**Send registration to:**

Task Force on New Health Practitioners  
Illinois State Medical Society  
55 E. Monroe, Suite 3510  
Chicago, IL 60603

(Make checks payable to ISMS)

Fee: \$20 advance registration (until October 17)  
\$25 at the door  
(covers cost of materials and meal)

(Refunds only if cancellation received before October 17)

Hotel accommodations should be made directly with the Continental Regency Hotel, Peoria.

### BRIEF SUMMARY

**Indications**—Symptomatic relief of anxiety and tension associated with anxiety disorders, other psychoneurotic disorders, transient situational disturbances, and functional or organic disorders. Symptomatic relief of acute alcohol withdrawal.

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**Contraindications**—Known hypersensitivity to the drug. Acute narrow angle glaucoma

**Warnings**—Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 18. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits)

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers

**Precautions**—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**Adverse reactions**—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

**Dosage**—ANXIETY—Usual daily dose 30 mg or less (start the elderly or debilitated at 7.5-15 mg). Adjust gradually within 15-60 mg daily range. Capsules and scored tablets: divided doses; or once daily h.s. (start patient at 15 mg) Single Dose Tablets, 22.5 mg (for patients stabilized on 7.5 mg t.i.d.) or 11.25 mg once daily at any hour. ALCOHOL WITHDRAWAL—In divided doses. 1st day 30 mg initially, then 30-60 mg. 2nd day 45-90 mg. 3rd day 22.5-45 mg. 4th day 15-30 mg. Then taper to 15-7.5 mg daily, and discontinue as soon as stable.

**Interactions**—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants.

**Overdosage**—Take general measures as for any CNS depressant

**Supplied**—Tranxene 3.75, 7.5 and 15 mg capsules and scored tablets. Tranxene-SD Half Strength 11.25 and Tranxene-SD 22.5 mg single dose tablets.

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**OB/GYN PHYSICIAN**—Excellent opportunity to join busy OB/GYN in multi-specialty group in midwestern community of 30,000 and drawing area of 100,000. Ideal place to raise family and easy access to metro areas. We offer excellent salary and fringes first year and equal partnership second year. Please send CV to K. H. Shons, Business Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Drive, Freeport, Illinois 61032 or call (815) 235-6131.

**FAMILY PRACTITIONER WANTED** to join well established practice in central Illinois community with JCAH 60 bed hospital. Guaranteed income, early partnership. Excellent potential. Send CV to 976 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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### SITUATIONS WANTED

**OB-GYN—BOARD ELIGIBLE**—seeks solo practice or association with either ob-gyn, or family practice physician. Write to Box #962 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**DERMATOLOGIST**, thirty-three years old, training recently completed, with flexible schedule desires part time (20-30 hours/week) association with clinic, health maintenance organization, or practicing dermatologist in Chicago metropolitan area. James M. O'Dowd, M.D., 307 Buckthorn Lane, Hillside, Ill. 60162.

**BOARD CERTIFIED INTERNIST**, young Stanford University clinical instructor seeks group or solo practice in Chicago area. Would also happily consider teaching in University setting. Contact Box #975 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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### MISCELLANEOUS

**PUBLISH OR PERISH?** Experienced Ph.D. scientist will do literature search, review and edit your articles. Call Dr. Ghouri 314-394-3242.

## ISMS Travel Programs 1981

The following ISMS-sponsored travel programs have been scheduled for 1981:

January 28 - February 11—SOUTH AFRICA (Johannesburg/Cape Town/Plettenberg Bay/Durban)

February 18 - February 25—Hawaii (an additional one week optional trip to the outer islands is available)

June 30 - July 12—Rhine/Alpine (Mainz, West Germany; Lucerne, Switzerland, Innsbruck, Vienna, Austria, and Salzburg, Austria)

July 26 - August 6—British Isles (Ireland, Scotland, England)

August 7 - August 16—Canadian Rockies (Vancouver, Banff, Lake Louise and Jasper)

August 29 - September 12—Alaska Cruise (San Francisco, Vancouver, Ketchikan, Juneau, Glacier Bay, Sitka, and Victoria)

September 9 - September 21—Italy (Naples, Rome, Florence, Venice, Capri and Sorrento)

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS members and auxiliary at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact ISMS headquarters.

# Illinois Housestaff News

## *Revised Principles of Medical Ethics*

### *One Resident's Opinion*

The American Medical Association Resident Physicians Section (AMA-RPS) held its annual meeting in July, in conjunction with the AMA's annual meeting in Chicago. For Illinois residents it was indeed a very successful meeting. Three Illinois residents were elected to offices on the national level of organized medicine.

L. Ann Nunnally, M.D., a resident at the University of Chicago, was elected to the AMA Council on Medical Education. Currently the Council is in the process of reviewing its report, "Future Directions for Medical Education," which could have a profound affect on medical education as we know it today.

David Olive, M.D., a resident at Northwestern University, was elected as Secretary of the AMA-RPS. Dr. Olive is also currently serving as the RPS alternate delegate to the ISMS House.

Larry Gratkins, M.D., a resident at Northwestern University and also current Chairman of the ISMS-RPS, has also been elected to the office of alternate delegate of the AMA-RPS.

Once again, the ISMS-RPS has shown that it is a major force in organized medicine. We congratulate Drs. Nunnally, Olive and Gratkins in their new responsibilities and know that they shall serve in the best interests of residents, on all levels of organized medicine, well.

Now is an ideal time for Illinois residents to become involved in all levels of the RPS. There are constantly new openings and opportunities for those who wish to participate. I am sure that any one of the above mentioned residents, or any

resident now holding an office or position in the RPS, would be happy to discuss issues or problems pertaining to membership, hospitals or training programs with anyone interested.

The 1980 Annual AMA meeting should be remembered as a turning point for the Society for two particularly significant positions. The first is the adoption of a new Code of Medical Ethics, the first revision in 23 years. The guarantee of freedom of choice for physicians and patients while emphasizing individual rather than collective responsibility in dealing with patient care go a long way toward modernizing medical ethics.

The second is the adoption of an absolute stand against any physician participation in capital punishment. The Judicial Council's Report provides clarification for AMA members in the gray area of "lethal injection laws" in states that authorize this form of execution or any other form of capital punishment.

The AMA has long asserted its desire for a leadership role in promulgating patient rights while receiving severe criticism as a conservative, reactionary body rarely taking the lead. The adoption of a more liberal philosophy with a move toward the middle-of-the-road; coupled with policies demanding an adequate distribution of health care based on society's needs; and an active membership could re-establish this leadership role.

The future promises to be interesting.

Larry Gratkins, M.D.  
Chairman, ISMS-RPS

## **IMPORTANT**

There are still openings for Residents on Illinois State Medical Society Councils. These councils deal with the policy making activities of the Society which will ultimately affect the physicians in Illinois. If you would be interested in serving in this capacity, please contact me through Mr. Perry Smithers, at the Illinois State Medical Society, located at 55 E. Monroe St., Suite 3510, Chicago, Illinois, 60603, or call at 312/782-1654.

\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.



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# EKG

(Continued from page 108)

**Answers: 1. E 2. E**

The simultaneous V<sub>1</sub>, II, V<sub>5</sub> rhythm strip shows a well functioning demand pacemaker seen in beats 1, 3, 4, 5, and 7 counting from the left. Beats 2 and 6 are sinus capture beats which demonstrate a prolonged PR interval and complete right bundle branch block. After the 7th beat, a series of sharp downward spikes at a rate of 120/minute appear and the pacemaker beats disappear. This is pacemaker inhibition. Large P waves can be seen which conduct to the ventricles with a complete right bundle branch block in a conduction ratio of 3:2. These beats are similar to the sinus capture beats 2 and 6. Pacemaker inhibition was used to evaluate the pacemaker's response to sense and capture the ventricles. This patient had a demand mode or R-wave inhibited pacemaker. A second external pacemaker was connected to

the patient by leads placed on the skin over the internal permanent battery pack. The external pacemaker sent stimuli that the permanent pacemaker interpreted as R waves. This activated the permanent pacemaker's demand mode and it turned off. Therefore, the pacemaker was functioning normally—able to sense and capture the ventricles. No evidence was found to support an inordinate change in the pacemaker threshold. In addition, pacemaker inhibition also revealed an underlying sinus rhythm which could conduct to the ventricles in a pattern of second degree atrio-ventricular block. The patient was not totally pacemaker dependent. In this fashion, the pacemaker was ruled out as a cause of his near-syncope. Other considerations in the differential diagnosis of near-syncope in this patient are: transient ischemic attacks due to cerebral vascular disease, exertional hypotension due to global ischemia and severe coronary artery disease, and paroxysmal ventricular tachycardia with hypotension. For further information on pacemakers, see Edward Chung: ARTIFICIAL CARDIAC PACING—PRACTICAL APPROACH, Williams and Wilkins, 1978. ◀

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# REPORT

## FOR *Illinois Physicians*

---

### Payment Information Program Started

The Chicago-based Blue Cross and Blue Shield Plan has implemented a new procedure to give physicians more information on claim payments.

The procedure, which went into effect October 13, provides an Explanation of Payments form under separate cover to compliment Payment Vouchers.

The Explanation of Payments will enhance the completeness of the Payment Voucher, thus eliminating the need for disapproval letters. Lines of Service that are disapproved will appear with explanations, which should reduce inquiries for clarification. Payment adjustments also will be reflected.

All claims processed for the period Friday through Thursday will appear in the Explanation of Payments and the following data elements will appear for each claim: Patient's Name; Age; Patient Num-

ber (for your use); Identification Number; Claim Number; and for each line of service, Service Date; Type of Service (T.O.S.); Place of Service (P.O.S.); Amount Billed; Paid; Ineligible; Message (only if line of service is disapproved); Check Number; and Totals for Claim Amount Billed; Claim Amount Paid; Claim Amount Ineligible and whether payment was made to you or our subscriber.

In addition to the above information, the last sheet will have a summary of claims paid to you and the subscriber, along with dollar amounts.

The information contained in the Explanation of Payments form should be a valuable reference for your patients' records.

If you have any questions, or desire a fuller explanation, please contact your Professional Relations Representative.

---

### General Motors Retirees Health Care Program

ILLINOIS GENERAL MOTORS EMPLOYEES AND RETIREES' MEDICAL AND SURGICAL BENEFITS ARE COVERED BY METROPOLITAN LIFE INSURANCE COMPANY. THEIR IDENTIFICATION CARDS DO NOT HAVE THE BLUE SHIELD EMBLEM. ILLINOIS PHYSICIANS ARE REQUESTED TO CONTINUE TO FILE THEIR CLAIMS WITH METROPOLITAN LIFE.

Since July 1, 1980, all Michigan and Florida General Motors retirees and their spouses have been included in a special Retiree Health Care Program. Effective October 1, 1980, the General Motors program was extended to all General Motors retirees in all States. This new program guarantees that physicians will receive payment for covered services based on the Illinois Blue Shield 100 percent Usual and Customary payments. General Motors retirees,

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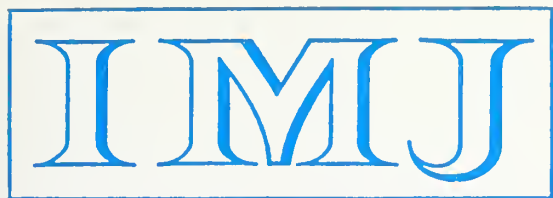
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Volume 158, No. 4

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October 1980

(USPS 258-160)

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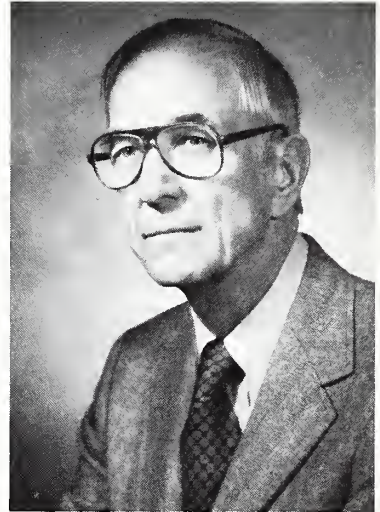
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# President's Page



*An Idea for The 80's:*

## **"If Men Were Angels, No Government Would Be Necessary"**

Alexander Hamilton

"I'll be There" is the theme of an AMA campaign designed to encourage a high voter turnout within our membership. It's a good idea.

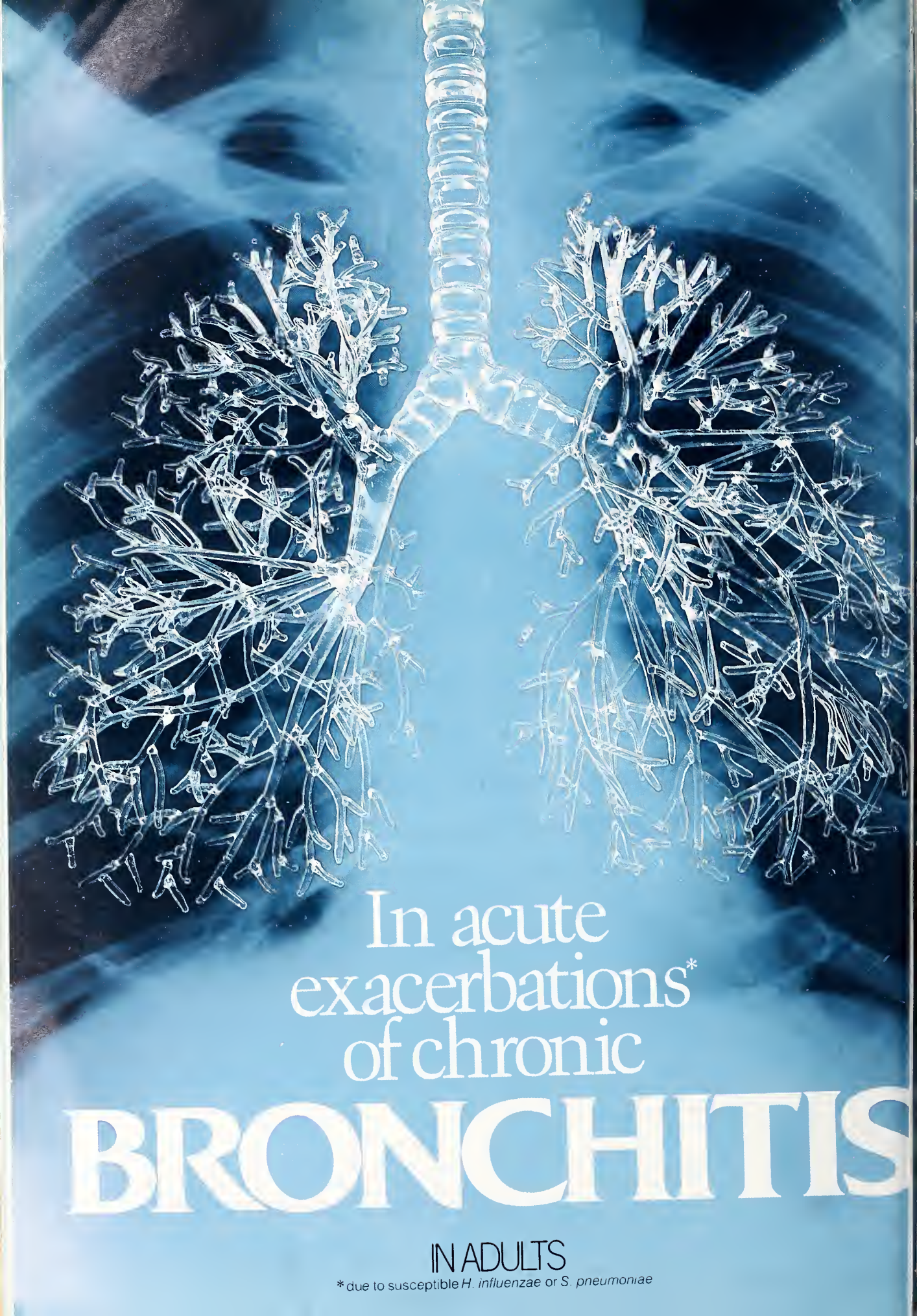
I urge you to participate in the selection of our local, state and national leadership. Don't think for one moment that your vote doesn't count. Election history abounds with examples of narrow victory margins.

In writing the Constitution, our Founding Fathers made no assumption that elected leaders would be selfless persons devoted to the public interest. Rather, the foundation of our government diffuses power so no group or person grows too powerful.

Vote!

A handwritten signature in cursive script that reads "Herschel Browns M.D.".

Herschel Browns, M.D., President



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# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's viewbox was contributed by Richard Marsan, M.D., associate professor of radiology, Loyola University Medical Center, Maywood. Dr. Marsan's co-authors were S. Ramamurthy, M.D., and D.S. Shah, M.D., of the Hines Veterans Administration Hospital in Hines, Illinois.*

**Patient A:** A 54 year old male with a one year history of increasing claudication in the right lower extremity involving the buttock, thigh and calf. Angiography demonstrates a 3-4 cm stenotic lesion involving the right external iliac artery. The remainder of the vascular structures appear near normal. The patient did not want to have surgery if it could be avoided.

**Patient B:** A 60 year old male with a long history of ischemic heart disease, diabetes, hypertension, obesity and claudication of both lower extremities. He has had a large non-healing ulcer on his left foot for three months. Angiography demonstrated extensive peripheral vascular disease with complete occlusion of both superficial femoral arteries and a short high grade stenosis of the left common iliac artery.



Figure 1 Patient A



Figure 2 Patient B

**The treatment of choice in these patients would be:**

1. Aortoiliac bypass graft
2. Iliac endarterectomy
3. Transluminal angioplasty
4. Aortofemoral bypass

(Continued on page 308)

# Illinois Housestaff News

## Match March II: A Resident's View

This time of year brings an annual ritual called the National Resident Matching Program (NRMP). Some 20,000 graduating senior medical students will be participating in this computerized dice game, competing for approximately the same number of accredited post-graduate training positions. Rising levels of anxiety, increasing gastric secretions and pathologic behavior patterns begin to manifest themselves more and more frequently as the January deadline approaches. But why the guise of being poorly prepared? The graduating senior has, in all likelihood, obtained a number of manuals, pamphlets and articles explaining everything from the appropriate length of one's sideburns to the latest conversation theory. The interviewee is, in short, well prepared for this ultimate ordeal.

Students, however, are not the only ones involved in this process. Professors, attending staff, administrators and residents all take part in the match march and, unfortunately, are prepared to a much lesser degree. In this discussion we limit ourselves to the house officer's approach to the interviewing process. He is usually asked by his residency director or chairman (read: their secretaries) to "show the seniors around" and answer their questions. What the house officer best represents is the antithesis of the prepared interviewer. More likely than not he will have been on call the previous night and is currently between cases in the operating room while simultaneously supervising clinic. This is no time to be playing tour guide. But, if you must, you might as well live up to your responsibilities. The following tactics are mentioned only to be condemned:

— *Constantly explain how overworked and underpaid you are*—Since you have apparently been singled out to do "penance," you might as well prepare these neophytes for what is to come. And by discouraging all but the most manic, you may be minimizing the "scut work" required of you in the future.

— *Compare your academic record with all potential candidates*—You were AOA and Student of the Year, weren't you? Make it clear that anything less has no chance. This technique is also good for minimizing questions, as the applicant

will fear appearing ignorant.

— *Ventilate all frustrations concerning your program*—What better opportunity to explain that your program has taken unfair advantage of you the last two years? Finally you have an audience which will actually listen to your complaints! What's more, it may prove particularly therapeutic.

— *Explain that the only means of entrance to your program is outside the Match rules*—After all, if it was good enough for you . . . This is an extremely effective ploy. It undermines the credibility of you, your program, and the NRMP simultaneously! A sweeping blow for integrity.

— *Cheerlead*—The residency probably doesn't have enough going for it anyway, right? This variation of fraternity rush week is particularly valuable if you can arrange to be overheard by your Chairman—it more than compensates for your monthly contributions to mortality and morbidity conferences.

— *Be evasive*—Haven't you learned anything from the hospital administration? A good tactic to practice if preparing for a career in academic medicine.

The variations are endless. But in all seriousness, the resident is frequently the most sought after and respected physician seen by potential candidates. Undermining your credibility with poor preparation or departmentally approved stock answers is truly a blow to the system. The residency candidate may frequently ask difficult questions, and you may be pressed for time, but honesty and thoroughness must be foremost in your responses. In part, it is your responsibility to help select which residency will best suit each student. To do this, the residency candidate must be given the best available advice. What could be worse than the student choosing a program with which he or she is not compatible? After all, look what happened to us.

Larry Gratkins, M.D.  
Chairman, ISMS-RPS

David Olive, M.D.  
Alternate Delegate, ISMS-RPS

### References

1. Golden, William E.: "Match March," *JAMA*: 243:10, 1047.

\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.





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## Clinics for Crippled Children Listed for November

Thirty eight clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 27 general clinics, 10 cardiac clinics and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 4 DuQuoin—Marshall Browning Hospital
- 4 Park Ridge Cardiac (a.m.)—Lutheran General Hospital
- 4 Park Ridge General (p.m.)—Lutheran General Hospital
- 4 Wheaton General—Marianjoy Rehab. Hosp.
- 5 Hinsdale—Hinsdale Sanitarium
- 6 Sterling—Sterling Community Hospital
- 6 Pittsfield—Illini Community Hospital
- 6 Effingham—St. Anthony Memorial Hosp.
- 6 Lake County Cardiac—Victory Memorial Hospital
- 7 Division Cardiac—U. of I. at the Medical Center
- 10 Peoria Cardiac—St. Francis Hospital
- 10 Chicago Heights Cardiac—St. James Hosp.
- 11 East St. Louis—Community Hospital
- 11 Peoria General—St. Francis Hospital
- 12 Joliet—St. Joseph's Hospital
- 12 Elgin General—Sherman Hospital
- 12 Chicago Heights General—St. James Hosp.
- 12 Rockford—St. Anthony's Hospital
- 12 Champaign-Urbana—McKinley Hospital
- 12 Springfield Ped-Neuro—St. John's Hosp.
- 13 Aurora Cardiac—Mercy Center for Health Care Services
- 13 Springfield General—St. John's Hospital

- 13 Macomb—Medical Bldg. of McDonough District Hospital
- 13 Anna—Union County Hospital
- 18 Maywood—Loyola Medical Center
- 18 Belleville—St. Elizabeth's Hospital
- 18 Rock Island Area General—Moline Public Hospital
- 18 Decatur—Decatur Memorial Hospital
- 19 Evergreen Park—Little Co. of Mary Hosp.
- 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
- 20 Centralia—St. Mary's Hospital
- 21 Kankakee Cardiac—St. Mary's Hospital
- 24 Chicago Heights Cardiac—St. James Hosp.
- 24 Peoria Cardiac—St. Francis Hospital
- 25 Maywood General—(half-day, ortho only)—Loyola Medical Center
- 25 Peoria General—St. Francis Hospital
- 25 Alton—Alton Memorial Hospital
- 26 Chicago Heights General—St. James Hosp.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

October 27	Sherman Hospital & A.C.S.	Elgin
October 27	Geneva Community Hospital & A.C.S.	Geneva
October 27	Berwyn Park District & A.C.S.	Berwyn

October 28	Palatine Public Library, Park District & A.C.S.	Palatine
October 28	Lutheran General Hospital & A.C.S.	Park Ridge
November 3	Copley Memorial Hospital & A.C.S.	Aurora
November 17	Christ Hospital & A.C.S.	Oak Lawn
December 1	Anchor & A.C.S.	Chicago

### 1981

Bi-Monthly	Skokie Valley Hospital	Skokie
January 5	Highland Park Hospital & A.C.S.	Highland Park
January 12	Resurrection Hospital & A.C.S.	Chicago
January 20	Lutheran General Hospital & A.C.S.	Park Ridge
January 26	Christ Hospital & A.C.S.	Oak Lawn
March 9	Lake Forest Hospital & A.C.S.	Lake Forest
March 23	Christ Hospital & A.C.S.	Oak Lawn
April 14	Lutheran General Hospital & A.C.S.	Park Ridge



# OBITUARIES

**\*\*Chainski, Edward L.**, Chicago, died August 5, 1980, at the age of 81. Dr. Chainski was a 1921 graduate of Loyola University Stritch School of Medicine. He also was a past president of the Lake Forest Hospital medical staff.

**\*Farney, William Emmett**, Springfield, died August 7, 1980, at the age of 63. Dr. Farney was a 1942 graduate from the University of Illinois College of Medicine.

**\*\*Jonas, William Paul**, Chicago, died August 11, 1980, at the age of 74. Dr. Jonas was a 1930 graduate of Loyola University Stritch School of Medicine.

**\*Leader, Leonard O.**, Chicago, died August 6, 1980, at the age of 71. Dr. Leader was a 1931 graduate from the University of Illinois Medical School. He also was on the staff of Mt. Sinai Hospital for 48 years.

**\*Lescher, Theodore Leander**, Chicago, died July 23, 1980, at the age of 71. Dr. Lescher was a 1933 graduate of Loyola University Stritch School of Medicine.

**\*\*Lewis, Willis I.**, Pompano Beach, Fla., died July 17, 1980, at the age of 86. Dr. Lewis, the 1954 ISMS president, graduated from the Loyola University Stritch School of Medicine in 1919, and began his practice in Royalton in 1925. He moved to Herrin in 1931, where he remained until retirement in 1963.

In addition to serving as president, Dr. Lewis was an ISMS delegate to the American Medical Association and a trustee for the Post Graduate Medical Association of North America. He was an active member of the American College of Surgeons, Illinois Obstetric and Gynecologic Society and Illinois Surgical Society. Long a member of the Williamson County Medical Society, Dr. Lewis' involvement in community and civic affairs included presidency of the Rotary Club and director of the Herrin Chamber of Commerce.

Services were held for Dr. Lewis in Pompano Beach, Florida, where he had lived since retirement.

**\*\*Meister, Earl Edward**, Aurora, died August 29, 1980, at the age of 85. Dr. Meister was a 1917 graduate of the Chicago College of Medicine and Surgery.

**\*\*Pilot, Isadore**, Chicago, died August 3, 1980, at the age of 84. Dr. Pilot was a 1917 graduate of the University of Illinois Medical School. He was on staff at both Louis A. Weiss Memorial and Bethany Methodist hospitals.

**\*Piszczyk, Edward A.**, died August 29, 1980, at the age of 72. Dr. Piszczyk, 1965 president of ISMS, was an internationally known authority in contagious disease and had served as field director of the Suburban Cook County Tuberculosis Sanitarium District since 1950. He graduated from the Loyola University Stritch School of Medicine in 1933 and earned a master's degree in public health from Harvard University six years later.

An ISMS Councilor from the third district, 1953-63, Dr. Piszczyk served as chairman of the Council (now termed the Board of Trustees) from 1960 through 1962.



A diplomate of the National Board of Medical Examiners, Dr. Piszczyk was a clinical professor and chief for the Loyola University Section on Public Health. At the University of Illinois, he was both clinical associate professor of preventive medicine

and community health for the Abraham Lincoln School of Medicine and also clinical associate professor of epidemiology for the School of Public Health.

Dr. Piszczyk was an ISMS delegate to the AMA, acting as both secretary and chairman of the delegation. He was a member of the AMA Council on Environmental, Occupational and Public Health, and chaired the ISMS Council on Environmental and Community Health.

Dr. Piszczyk was an active member of the Chicago Medical Society, where he served as a Councilor for many years, and chaired a number of committees.

He held a large number of community service posts, including chairmanship of the IDPH Board of Public Health Advisors, and presidency of the Illinois Public Health Association.

Dr. Piszczyk's fellowships included the American Public Health Association, American College of Preventive Medicine and American College of Chest Physicians. An associate fellow of the American Academy of Pediatrics, Dr. Piszczyk was a member of the Founder's Group, American Board of Preventive Medicine and Public Health.

**\*\*Rozycki, Walter**, Chicago, died August 30, 1980, at the age of 82. Dr. Rozycki was a 1929 graduate of Akademia Medyczna Wydzia Lekarski, Poznan, Poland.

**\*\*Sullivan, Harold Patrick**, Chicago, died September 2, 1980, at the age of 86. Dr. Sullivan was a 1923 graduate of Loyola University Stritch School of Medicine.

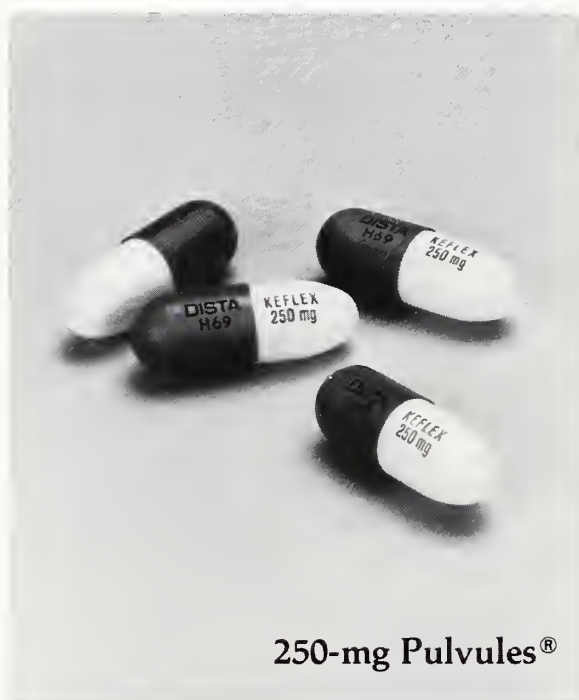
**\*\*Thill, John C.**, Chicago, died August 10, 1980. Dr. Thill was a 1925 graduate of Northwestern University Medical School.

**\*White, Noland Winford**, Centralia, died July 23, 1980, at the age of 69. Dr. White was a 1936 graduate from Washington University Medical School. He also was a past president of the Marion County Medical Society.

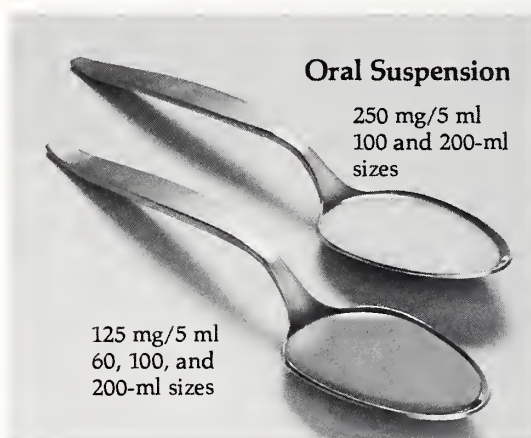
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# Case Reports

## *An Unusual Case*

### Tubal Hydatidiform Mole

ROGER P. SMITH, M.D./URBANA

*Ectopic (tubal) hydatidiform moles are an exceedingly rare occurrence. Presented is a patient with this lesion who had previously had a tubal ligation and during the course of her evaluation continued to have regular menstrual periods. A brief review of the literature is also presented.*

Hydatidiform mole represents one in 2500 pregnancies in North America and as many as one in 82 pregnancies in Taiwan.<sup>1</sup> Ectopic pregnancies represent approximately one in 300 pregnancies.<sup>2</sup> The incidence of tubal hydatidiform mole, however, is exceedingly rare. Pettit,<sup>3</sup> in 1941, reviewed the literature

to that date and found 13 cases (to which he added one of his own) and in 1948, Chalmers<sup>4</sup> also added another patient. In 1954, Sutherland<sup>5</sup> reported a tubal mole in conjunction with a normal intrauterine gestation, as did Crisp<sup>6</sup> in 1956. Miller,<sup>7</sup> in 1953, and Kika and Matuda,<sup>8</sup> in 1957, each added cases, bringing the

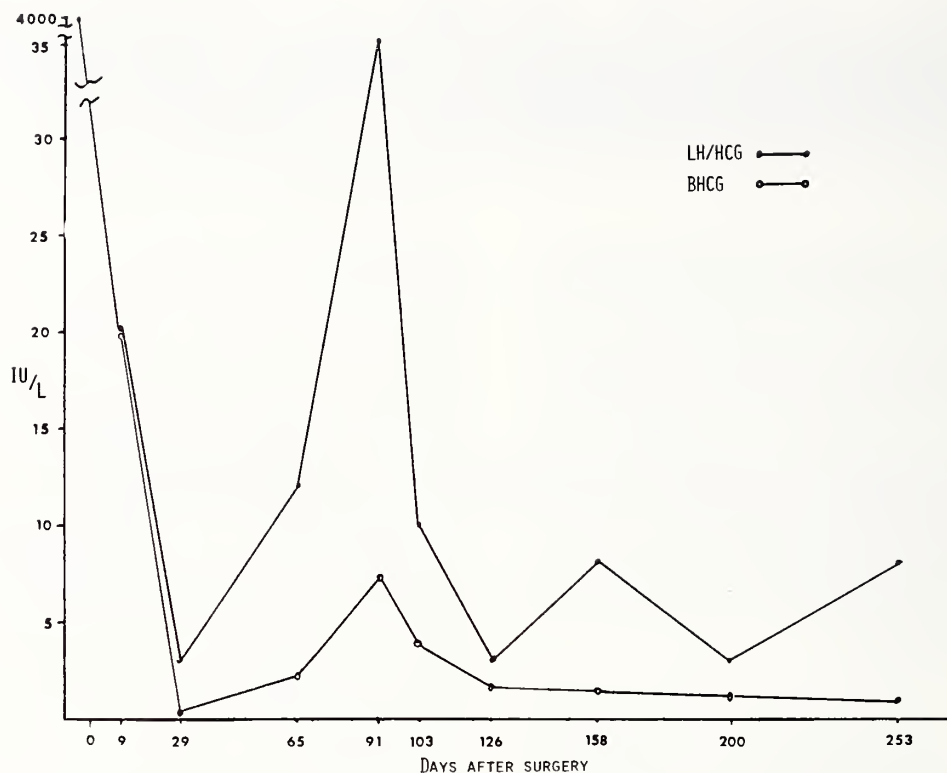
total to 19. In 1958 and 1959, Valente<sup>9</sup> and Qjanen<sup>10</sup> added cases. The twenty-second case was reported by Westerhout,<sup>11</sup> in 1963. Adli,<sup>12</sup> in 1976, added the twenty-third case and this report presents an additional, somewhat unusual, case.

#### Case Report

The patient is a 30-year-old female, gravida 0, one and one-half years after laparoscopic tubal ligation, who presented with a history of right lower quadrant intermittent sharp pain. Initial evaluation that day showed a tender right adnexal fullness difficult to evaluate because of guarding. The patient was seen one week later when the pain had been absent for four days. The right adnexa was found to be approxi-



**ROGER P. SMITH, M.D.**, is a board certified obstetrician and gynecologist affiliated with the Carle Clinic in Urbana. A clinical instructor at the UI School of Basic Medical Sciences, Dr. Smith is Junior Fellow Section chairman for the Illinois Chapter, American College of Obstetricians and Gynecologists.



**Figure 1**  
Serum levels of LH/HCG and Beta specific HCG were determined by the Choriocarcinoma Laboratory at Northwestern University. Values of BHCG have remained within the normal range of 0-4 IU/L. After 350 days the patient's titre was 2.1 IU/L.

mately four to six cm in size, soft, cystic, mildly tender, smooth, and mobile. The uterus was firm, anterior, and normal. The patient's previous menstrual period had occurred six weeks earlier. Two weeks after this second visit when the patient had had a normal, although delayed, period, the mass had remained unchanged. On the first day following onset of menstruation, sudden onset of right lower quadrant pain necessitated an Emergency Room visit. The Emergency Room examination again showed a firm, anterior, normal size uterus, with the adnexal mass, somewhat tender, but unchanged in size. A sample for urinary chorionic gonadotropin (UCG) was sent, and returned as positive. The patient was admitted to the hospital for observation overnight. A repeat UCG was carried out the next morning and also was positive. The patient's pain disappeared within two hours after admission and was totally absent for the next 24 hours. The ad-

nexal mass did not change. Ultrasound examination of the pelvis was carried out showing a small anterior, non-pregnant uterus, and a semi-solid cystic mass in the right adnexa.

Follow-up examination showed no further abdominal pain and no change in pelvic findings. Because of the unexplained UCG level, a Beta specific Human Chorionic Gonadotropin (BHCG) was sent to a choriocarcinoma laboratory. However, because of sample breakage in transit and subsequent delays, results were not available prior to the exploratory laparotomy. The patient had another totally normal period during the interim.

The patient was admitted six weeks after first visit for exploratory laparotomy, right salpingo-oophorectomy, and probable hysterectomy. She was on no medications and knew of no allergies. Physical examination at admission was unremarkable with the exception of a butterfly tattoo in the right mid por-

tion of the lower anterior abdominal wall. Pelvic findings were again unchanged with a small, firm, mobile, anterior uterine corpus. The left adnexa was normal, and the right adnexa had a four to five cm soft, cystic mass which was smooth, mobile, and only mildly tender. Preoperative laboratory values were within the normal range, including a hemoglobin of 13.9 grams per dL.

Abdominal laparotomy revealed an enlarged right adnexal mass compatible with the previous pelvic findings. The ovary was densely adherent and involved in the mass, which on frozen section examination consisted primarily of blood and tubal tissue with no villi identified. Because there was no explanation for the positive UCG and the possibility of ovarian choriocarcinoma had not been eliminated, right salpingo-oophorectomy and total abdominal hysterectomy were carried out at that time without technical difficulty. The patient tolerated the procedure well. The patient's



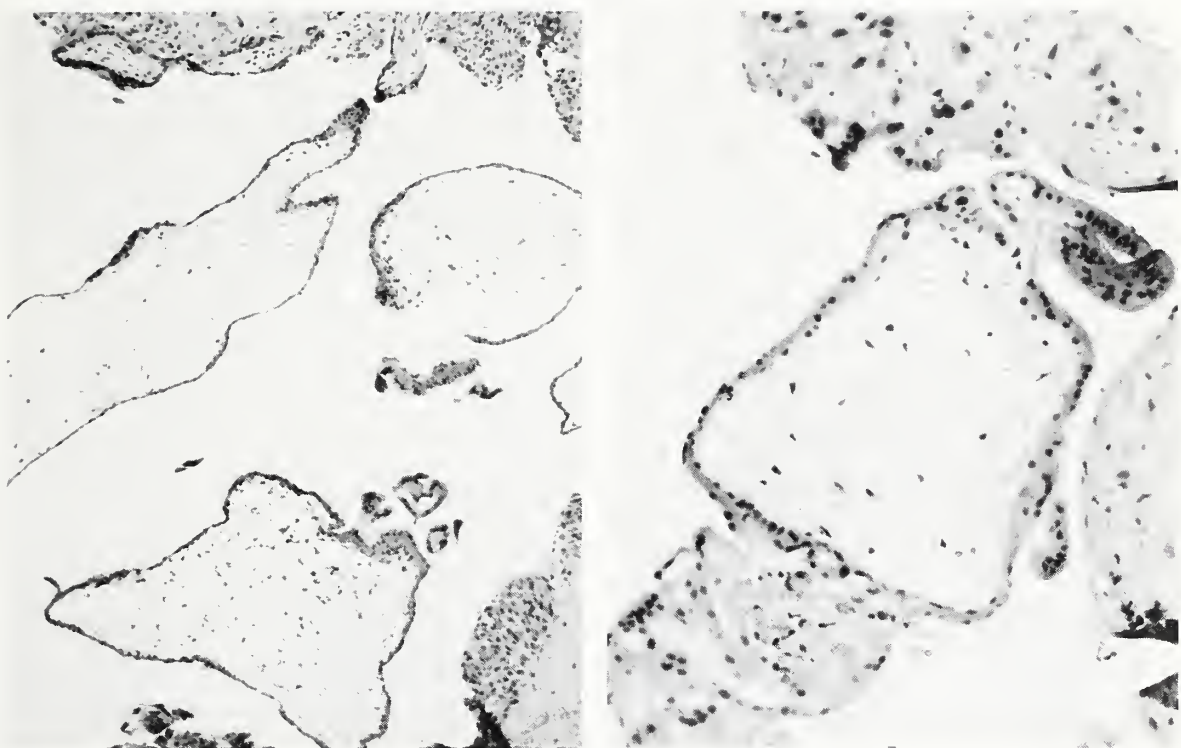


Figure 2

Trophoblastic proliferation was found throughout the tubal villi examined. The specimen is magnified. (H & E stain).

postoperative course was uneventful. By the third postoperative day, pathologic diagnosis had been established as multiple cystic degenerating chorionic villi, found within the tubal portion of the mass. There was trophoblastic proliferation and, based on pathologic examination, the diagnosis of ectopic hydatidiform molar pregnancy was made (Figure 1). No estimate of pregnancy duration could be made. The patient was discharged on the fifth postoperative day in excellent condition. Follow-up was carried out as an outpatient. The preoperative BHCG titer showed a titer of 4000 IU/L. Follow-up BHCG titers are shown in Figure 2. Pathologic diagnosis was confirmed by the choriocarcinoma laboratory after review of the pathology slides.

### Discussion

Although most hydatidiform moles follow a benign course, 3.5% may progress to invasive mole or choriocarcinoma.<sup>13</sup> Although ecto-

pic hydatidiform mole is rare, when encountered it must be handled by aggressive local excision and careful monitoring of Beta specific HCG titers postoperatively. This case also should serve as a reminder that previous tubal ligation does not preclude pregnancy, and episodic vaginal bleeding does not rule out a pregnancy. ◀

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ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

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# Illinois Society, American Association of Medical Assistants

## Attention ISMS Members AAMA Announces Education Seminars

BY MARYGRACE SANDERSON  
COOK COUNTY SOUTH CHAPTER

Illinois Society members are actively participating in continuing education programs on the national, state and local county levels and would like to invite all Illinois physicians to encourage their medical assistants to participate in the many educational programs offered.

### *Calender of Events for 1980*

September 21, 1980 Illinois Symposium  
Collinsville, Il.

October 5th Personal Development Day  
Mattoon, Il.

October 13 thru 17 A.A.M.A. Annual Meeting  
Kansas City, Mo.

November 9 Travel Course  
Decatur, Il.

Jan. 25, 1981 Council  
Chicago area

### *EMT'S "THIS ONES FOR YOU"*

Randolph and St. Clair Chapter host the 1980 Illinois Society Educational Symposium at the Holiday Inn, Collinsville, on September 21, 1980 8a.m. to 3p.m. Five CEU's will be awarded to EMT's and medical assistants attending the program. In the first "Gold Medal of Knowledge," David Paul, M.D., Dept. of Emergency Medicine, Belleville Memorial Hospital, will review emergency procedures in a critical situation. Bjong Suhn Tschoe, M.D., Plastic Surgery Consultants Ltd., Belleville, will discuss up-to-date reconstruction of the hand. Donal Serot, M.D., Orthopedic Associates, Belleville, will review symptoms and treatment for common sport injuries. Mr. Donald Courtial, Physical Therapist, Memorial Hospital, Belleville, will instruct participants in the act of renewal and relaxation in the whirlwind of our professional lives.

Medical assistant members and non-members,

physicians and other health care personnel are invited to attend.

Coles and Cumberland Medical Assistants are planning a Personal Development Day on October 5, 1980 at the Holiday Inn, Mattoon. Details will be coming with Executive Memo.

An outstanding AAMA 24th Annual Meeting is planned at the Hyatt Regency Hotel, Kansas City, Missouri, hosted by the Kansas Society on October 13 thru 17, 1980. The Convention Theme is "AAMA: Where Yesterday Meets Tomorrow." National Society election of officers, continuing education courses in public relations and health careers, diabetes and diet control, organizing and preparing a medical paper, medical records and economics in the medical office will be offered. Kansas City at its best awaits Medical Assistants from all over the country.

For Membership information contact Elaine Kaiser, CMAA, president, 9103 Sandpiper Court, Orland Park, IL 60462 or Marygrace Sanderson, public relations committee chairman, 501 Heathermead Road, Matteson, IL 60443.

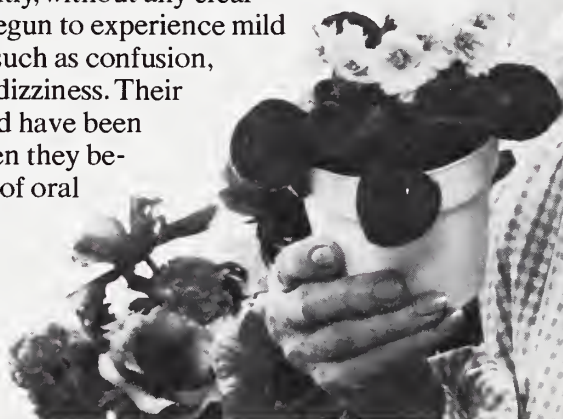
### **National News Note**

The AAMA Board of Trustees recently named Ina L. Yenerich, R.T., CMA-AC, executive director of the association. Ms. Yenerich has served in major posts within hospital administration as well as medical assisting education. She was appointed assistant executive director in summer of 1978, and was named acting director following the February, 1980 retirement of Dene R. Murray, CAE. She is former vice-chairman of the AAMA Guided Study Committee and was instrumental in development of AAMA's highly-successful home study course on anatomy, terminology and physiology. ◀

# The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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**Dosage and Administration:** 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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# Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

## Arthritis/Dermatitis Syndrome - Part II

A 23-year-old male was seen for joint pains and a skin rash. Six days earlier he had noted pain beginning in his ankles and knees which progressed rapidly to involve wrists and shoulders. Over the next few days, he noted warmth and swelling about the knees and small finger joints. One day before admission, a pruritic patchy erythematous rash developed over his legs and abdomen, and prompted his emergency room visit.

He had not noted fever, but complained of some malaise. A loss of taste for cigarettes had recently occurred. He gave no history of recent sore throat, urethritis, conjunctivitis, or change in color of stool or urine. There was no prior history of arthritis or rash. He had no known allergies, was on no medications, and denied alcohol or drug abuse.

On physical examination, temperature was 37.5°C. Skin revealed several 5cm erythematous, raised urticarial-like lesions over his trunk and extremities. Scleral icterus was not noted. Warmth, erythema and swelling were seen about several MCP and PIP joints of the hands, and an effusion was present in both knee joints. Shoulders, elbows, hips and wrists revealed tenderness to motion without objective signs of inflammation. Other positive findings were confined to the abdomen where a nontender liver was palpated 3cm below the costal margin with a total span of 11 cm. A spleen was not palpable.

### Laboratory

Hemoglobin was 13.1; hematocrit was 39%. White blood count was 9100 with 65% polymorphs; atypical monocytes were not present. SMA 18 revealed: SGOT 130; SGPT 158; bilirubin 1.9 total and 1.0 direct. Except for a min-

imally elevated alkaline phosphatase, the rest of the SMA 18 was normal. Coagulation profile was normal. The urine was of normal color, without cells, and was sterile on culture. Throat culture was negative for beta-strep. ASO, AHT and Anti-DNase B titers were normal. Monospot was negative. Sedimentation rate was 45mm/hour westergren. Rheumatoid factor and anti-nuclear antibodies were absent from serum, and complement levels were normal. Hepatitis-B surface antigen (HbsAG) was present in serum, and hepatitis-B surface antibody (HbsAB) was absent. Chest-Xray was unremarkable. Joint Xrays revealed only mild soft tissue swelling about the hands and knees. Left knee aspiration revealed clear synovial fluid with good viscosity: WBC count was 5000 with 50% polymorphs; glucose was 70 (simultaneous serum was 90); crystals were absent; gram stain and cultures were negative.

### Comment

The association of hepatitis with polyarthritis and dermatitis was initially described in 1843<sup>1</sup> by Sir Robert Graves: "A person laboring under inflammation of the joints gets an attack of hepatitis accompanied by jaundice, and this is followed by urticaria." Acute onset of symmetric polyarthritis or arthralgia occurs in up to 20% of patients with serum hepatitis (Hepatitis B) infections, and more rarely, other viral hepatitis.<sup>2-4</sup> Generally attacking multiple joints at the onset, it may progress in an additive or migratory fashion, and often involves both large and small joints. Knees and ankles are common disease sites, with shoulders, wrists, hips and elbows frequently accompanying them. MCP and PIP joint in-

involvement is as frequent as knees, and such a pattern in combination with skin lesions may mimic acute rheumatic fever or SLE. Examination often reveals no evidence of active inflammation about painful joints, although frank synovitis may occur. Synovial fluid, when present, varies from mildly to severely inflammatory with variable numbers of white blood cells and polymorphs. Synovial fluid glucoses and cultures are normal. Xrays, usually normal, may reveal soft tissue swelling on occasion. Articular symptoms predate onset of jaundice by an average of two weeks, and in anicteric hepatitis patients, may be the only clinical sign of the underlying viral infection.<sup>5</sup> Liver enzymes, if drawn, will be elevated in most patients at that time. More rarely, jaundice occurs simultaneously or even pre-dates articular symptoms. Dermatitis occurs in 35% of patients with this syndrome, and only rarely in the absence of articular disease. Rashes are macular, maculopapular, or urticarial, and often itch. Erythema marginatum, erythema multiforme, and petechial rashes have also been noted. Nodules are not a feature of the disease. Total resolution of lesions is the rule, as the illness is self-limited, and therapy is often ineffective in speeding the resolution of symptoms.

Recent work has shown the syndrome to be serum-sickness like in its pathogenesis: immune complexes composed of viral antigen and host antibody fix complement, circulate and disseminate through the blood stream to joints and skin, causing local inflammation and vasculitis. Indirect evidence for this comes from the finding of decreased levels of complement components in serum and synovial fluid of patients with serum hepatitis and arthritis, while patients without arthritis have normal or elevated complement levels.<sup>6</sup> The lowered complement levels, especially in synovial fluid, suggest immune complex activation with resultant complement consumption as the pathogenesis of the articular symptoms. Wands, *et al.*,<sup>7</sup> have found cryoglobulins containing HbsAG-AB immune complexes in all patients having active hepatitis-B infection. Immune complexes in hepatitis-B patients with the arthritis/dermatitis syndrome contain complement components and a preponderance of antibody subtypes with the ability to fix complement, whereas immune complexes in the hepatitis-B patients without the syndrome do not. This further suggests activated immune complexes as the pathogenetic mechanism of the articular and dermatologic symptoms.

The syndrome is self-limited, lasting an average of 5-7 days, and abates without residual symptoms. Treatment is symptomatic, with bed

rest or aspirin adequate for most patients. Steroids, which may delay healing of the hepatitis, are contraindicated. Loss of articular symptoms is associated with normalization of cryoglobulin and complement levels, and presumably is related to loss of viral antigen in the circulation as recovery begins. In chronic hepatitis-B antigenemia, such as that seen in patients who are chronic antigen carriers or have chronic active hepatitis, chronic immune complex diseases such as polyarteritis nodosa<sup>4,8</sup> or chronic glomerulonephritis<sup>2</sup> may be seen.

## Conclusion

Acute onset of a symmetric polyarthritis and urticaria, together with elevated liver enzymes, suggested the possibility of hepatitis-B associated arthritis/dermatitis syndrome in this young adult male. The presence of HbsAG in his serum was confirmatory. The patient was placed at bed rest, and within three days darkening of his urine and onset of icterus occurred. The liver became progressively more enlarged and tender, and enzymes became more elevated. Simultaneously joint and skin manifestations abated, and the patient lost his HbsAG positivity. Convalescence over six weeks resulted in complete recovery of liver function with return of tests to normal. On follow-up visit three months later, no residual articular was noted, and the serum now showed HbsAB positivity. ◀

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*Editor's Note: This article is the second of a three part series. The last segment will be featured in a forthcoming issue.*



# Doctor's News

**FDA IMPLEMENTS REGULATIONS**—The Food and Drug Administration has implemented final regulations establishing requirements and procedures for preparation and distribution of patient package inserts (PPI). Further, proposed regulations provide draft guidelines for PPIs for ten drugs or drug classes. The leaflets will be produced directly or indirectly by drug manufacturers and distributed by pharmacists or physicians.

Concurrently, the United States Pharmacopeial Convention will explore establishing a National Distribution Center for PPIs. Further information may be obtained by writing the USPC, 12601 Twinbrook Parkway, Rockville MD 20852.

**FRIEND OF THE COURT**—ISMS will file a friend-of-the-court brief supporting Central DuPage Hospital's appeal of a court ruling—issued in a malpractice suit—which could jeopardize confidentiality of patients' hospital records. The trial court ruling held that a hospital must release patient records despite statutory confidentiality provisions of the physician-patient relationship.

**CME FEES INCREASE**—The ISMS Board of Trustees approved an increase in CME accreditation fees effective January 1, 1981. The new fees will be \$500 for physician organizations of 49 or fewer members and \$750 for all other applicants. The registration fee (\$100) remains at the same level.

**WORKMEN'S COMPENSATION**—Under legislation recently signed by the governor, impartial medical review for disputed cases at the appellate level will be provided. Presidents of Illinois specialty societies will be asked to provide names of physicians willing to serve on impartial panels. Each specialty society is being asked to submit names of at least two physicians from each ISMS Trustee District who, preferably, are board certified, endorsed by the county medical society and hold ISMS membership.

**NEW NURSING POSITION STATEMENT ADOPTED**—The ISMS Board of Trustees acted to emphasize current policy on nursing education which states: "ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation." Further, the following position was adopted by the Board: "ISMS encourages retention and expansion of diploma nurse education programs through support for accreditation of such programs by the Board of Higher Education and the North Central Association of Colleges and Secondary Schools, expanded financial support from the state and other agencies, and recognition of the high quality care provided by diploma school nurses; and that ISMS support the concept of career ladder opportunity in the nursing profession."

**NEGOTIATIONS TRAINING PROGRAM PLANNED**—ISMS will co-sponsor an AMA-produced negotiations training program in conjunction with a 1981 House of Delegates meeting, if scheduling permits. Registration for the program, which would offer Category 1 CME credit, would be \$150. Further details will be published in *IMJ* when available.

**PHYSICIANS IN THE NEWS**—Governor Thompson has appointed members of the newly-formed IDPH Medical Advisory Board. The Board will be composed of the following physicians: **Audley F. Connor, Jr., M.D.**, Chicago; **Richard Suhs, M.D.**, Springfield; **Noel Bass, M.D.**, Joliet; **J. Robert Buchanan, M.D.**, Chicago; **Richard Moy, M.D.**, Springfield; **Hugh Rohrer, M.D.**, Peoria and **Samuel Andelman, M.D.**, Skokie. (Confirmation of these nominees is expected by the Senate when the legislature reconvenes after November elections.) The appointments are designed to effect a balance of members from private practice, medical school and public health administration.

**F. Howell Wright, M.D.**, Chicago, was recently presented the American Academy of Pediatrics Abraham Jacobi Memorial Award. Dr. Wright is emeritus professor of pediatrics at the University of Chicago. . . . The Illinois Society of Anesthesiologists has elected **Ronald F. Albrecht, M.D.**, Chicago, to serve as their 1980-81 president. Other new officers are **Bernard V. Wetchler, M.D.**, Peoria, vice-president; **Behrooz Zahed, M.D.**, Chicago, secretary and **Morton Shulman, M.D.**, Highland Park, treasurer.

**PHYSICIAN ADVERTISING**—Statutory authorization—outlined in the reference section of this issue—incorporates guidelines for physicians electing to advertise their services. Members are advised that commercial solicitations—such as that promoted for telephone book “Yellow Pages,” through the Donnelley Co.—may not comply with the legal requirements and regulations on physician advertising. Persons seeking to advertise their services should consult with the Illinois Department of Registration and Education, 320 Washington, Springfield 62786 (217) 785-0822, as to statutory and regulatory requirements.

**MORE REGULATORY NEWS**—The Illinois Department of Registration and Education has promulgated a form to be completed by physicians employing physician’s assistants. The Department notes that PAs may be employed only by a physician—not a hospital or facility. The “Certificate of Employment, Physician’s Assistant,” incorporates physician identification information and states: “This is to certify that I am an Illinois Licensed Physician, License No. \_\_\_\_\_, and that I intend to act as the primary supervising physician and assume supervisory control over the above-named physician’s assistant, beginning \_\_\_\_\_. I ( ) do ( ) do not intend to have an alternate supervising physician to supervise in my absence.” The form includes a space for name, license number and signature of the alternate supervising physician, if applicable. The forms, which are mandatory, may be obtained by writing the Department at 320 W. Washington St., Springfield, IL 62786, Attention: Medical Section.

**DANGEROUS DRUGS COMMISSION NOTES**—The US Drug Enforcement Administration has implemented final rules classifying dextropropoxyphene (Darvon) as a Schedule IV narcotic drug. DDC advises that this ruling will preclude use of this drug for treatment of drug dependence disorders. The only drug authorized for drug dependence treatment under FDA regulations is methadone, and use of Darvon to treat opiate dependent persons must terminate by October 22, 1980.

**TROPICAL DISEASE EXPERTISE**—The American Society of Tropical Medicine and Hygiene is updating a directory of persons expert in clinical tropical medicine. IDPH advises that readers with expertise may wish to be included in the directory, and that other readers may find the Directory useful. Further information may be obtained by writing Elizabeth Barrett-Connor, M.D., Chief, Division of Epidemiology, Dept. of Community Medicine M-007, University of California, San Diego, LaJolla CA 92093. (For information on an upcoming continuing medical education program on this topic, please see page 186.)

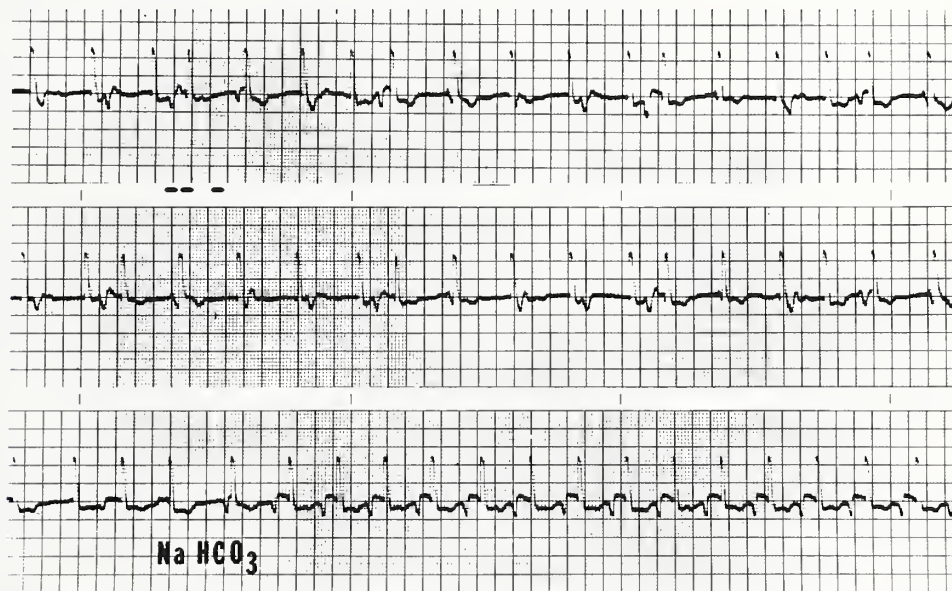
**HOSPITALS AND THE NURSING SHORTAGE**—The Institute of Medicine of Chicago will host a workshop on hospitals and the nursing shortage on Friday, November 21, at the Chicago Continental Plaza Hotel. Admission for Fellows of the Institute, including lunch, is \$40. Non-members are welcome at a cost of \$45. Further information may be obtained by writing: Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago IL 60604; (312) 663-0040.



# EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnor, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a seventy-eight year old man with a long history of coronary artery disease. He had sustained three myocardial infarctions and a bout of congestive heart failure. He was now admitted to the coronary care unit for worsening chest pains and shortness of breath. Cardiac physical examination showed a ventricular gallop and tachycardia. Pulmonary exam showed bilateral fine crepitant rales in both lung bases. A chest X-ray demonstrated cardiomegaly and pulmonary congestion compatible with pulmonary edema. Initial laboratory values were: BUN 52 mg %, creatinine 1.6 mg %, sodium 130 mEq/liter and potassium 4.4 mEq/liter and normal cardiac enzymes. His digoxin was maintained, sublingual and oral nitrates were started, and diuretic therapy was increased. At the end of the first day in the coronary care unit, he spiked a temperature to 39°C. following a shaking chill. His blood pressure fell transiently. After blood, urine, and sputum cultures were obtained, aqueous penicillin G was started intravenously in divided doses totalling twenty million units per day. Two days later he was clinically improved when this ECG rhythm strip was taken. Sodium bicarbonate was administered just prior to the last strip.*



## Questions:

1. The top two ECG rhythm strips prior to sodium bicarbonate administration show(s):

- A. A junctional tachycardia at a rate of 90 beats/minute.
- B. Sinus capture beats with incomplete atrio-ventricular dissociation.
- C. Evidence for an acute myocardial infarction.
- D. A slow ventricular tachycardia.
- E. All of the above.

2. After one ampoule of sodium bicarbonate (44 mEq) was given, a sinus tachycardia of 115 beats/minute promptly started. The most likely cause of this cardiac arrhythmia shown in the top two ECG strips in this patient is:

- A. Impending septic shock.
- B. Another acute myocardial infarction.
- C. Hyperkalemia.
- D. None of the above.

(Continued on page 305)

# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603; (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

## NOVEMBER

### Anesthesiology

**Regional Anesthesia & Therapeutic Nerve Blocking**  
For: Anesthesiologists. Lecture, Nov. 3 (5 days), Chicago. **Speaker:** Alon Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 10. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Arthritis

**Rehabilitation of the Patient with Arthritis**  
For: MD's. Course, Nov. 20-22, Chicago. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior, Chicago 80811. **Cosponsor:** American Academy of Physical Medicine and Rehabilitation. **Fee:** \$150, MD; \$90, resident. **Credit:** Category 1, 21 hours. **Contact:** Don Olson. **Phone:** 312/649-8179.

### Emergency Medicine

**Emergency Care, Current Knowledge and Skills**  
For: emergency physicians, FP's, internists, pediatricians, general surgeons. Symposium, Nov. 13-15, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Fee:** \$250. **Reg. limit:** 100. **Credit:** Category 1, 16 hours; AAFP Elective, 16 hours; ACEP, Category 1, 16 hours. **Contact:** Kathy Mulherin-Carroll. **Phone:** 312/942-7119.

### Emergency Medicine/Surgery

**Multiple Systems Trauma: 1980**  
For: MD's. Lectures/workshops, Nov. 5, St. Louis, MO. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$40. **Reg. limit:** 200. **Credit:** Category 1, 7 1/2 hours, AAFP Prescribed, 7 1/2 hours. **Contact:** Loretta Giacometto. **Phone:** 314/367-9673.

### Emergency Medicine

**Advanced Cardiac Life Support**  
For: CPR certified MD's. Course, Nov. 8-9, Chicago. **Sponsor:** University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. **Cosponsor:** Chicago Heart Association. **Fee:** \$150. **Reg. limit:** 48. **Credit:** Category 1, 16 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/947-7084.

### Endocrinology

**Clinical Endocrinology for 1980**  
For: GP's, Pediatricians, Internists, Gynecologists, General Surgeons. Course, Nov. 1, Chicago. **Fee:** \$40. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Sponsor:** The University of Chicago, 950 E. 59th St., Box 139, Chicago 60637. **Contact:** Mary Ann Dillon. **Phone:** 312/947-7084.

### Family Therapy

**Working with the Divorce Process**  
For: Psychiatrists, GP's, FP's, Pediatricians, Obstetricians, Urologists. Workshop, Nov. 7, Evanston. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Northwestern Memorial Hospital; Northwestern University Medical School. **Fee:** \$50. **Reg. limit:** 100. **Credit:** Category 1, 6 hours. **Contact:** Laurie Anderson.

### Family Therapy

**Paradoxical Techniques in Family Therapy**  
For: Psychiatrists, GP's, FP's, Pediatricians, Obstetricians, Urologists. Course, Nov. 15, Chicago. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Northwestern Memorial Hospital; Northwestern University Medical School. **Fee:** \$50. **Reg. limit:** 100. **Credit:** Category 1, 6 hours. **Contact:** Laurie Anderson.

### Family Therapy

**Law in the Everyday Practice of Psychotherapy**  
For: Therapists, GP's. Workshop, Nov. 21-22, Chicago. **Speaker:** Sandra Nye, JD, MSW. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. **Cosponsors:** Northwestern Memorial Hospital; Northwestern University Medical School. **Fee:** \$100. **Reg. limit:** 50. **Credit:** Category 2, 12 hours. **Contact:** Laurie Anderson.

### Infectious Diseases

**Respiratory Viral Infections**  
For: MD's. Lecture, Nov. 12, 2:00 p.m., Rockford. **Speaker:** George Jackson, MD. **Sponsor:** Div. of Infectious Diseases, Rockford School of Medicine, University of Illinois College of Medicine. **Fee:** \$10. **Credit:** Category 1, 2 hours. **Contact:** Office of CME. **Phone:** 815/987-7140.

### Installing Computers

**Choosing and Using a Computer in a Private Medical Practice**  
For: MD's. Lecture/demonstration, Nov. 21-22, Washington, DC. **Sponsor:** University of Health Sciences/The Chicago Medical School, 2020 W. Ogden Ave., Chicago 60612. **Fee:** \$260. **Reg. limit:** 200. **Credit:** Category 1, 15 hours. **Contact:** Susan Crabtree, One Chapman Rd., Burlington, IL 60109. **Phone:** 312/683-2066.

### Internal Medicine

**Medical Knowledge Self-Assessment Program V**  
For: Internists. Home Study Program. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, Penna 19104. **Fee:** \$75, ACP members; \$50, ACP associates; \$150, non-members. **Credit:** Category 5(d), 22 hours. **Contact:** Eleanor Gruber. **Phone:** 215/243-1200.

### RECENT CME ACCREDITATIONS

#### The ISMS Committee on CME

Accreditation has approved the CME programs of

the following institutions:  
Carle Foundation Hospital, Urbana  
Copley-Mercy CME Consortium,  
Aurora

DuPage County Medical Society  
Ingalls Memorial Hospital, Harvey  
Little Company of Mary Hospital,  
Evergreen Park

Mazel Medical Center—Edgewater  
Hospital, Chicago

St. Joseph Hospital, Chicago  
Skokie Valley Community Hospital,  
Skokie

### Medicine

**Transfusion Reactions**  
For: MD's. Lecture, Nov. 20, 7:00 p.m., Davenport, IA. **Speaker:** Richard Walker, MD. **Sponsor:** Mississippi Valley Regional Blood Center, 3425 E. Locust St., Box 70, Davenport, IA 52803. **Reg. deadline:** 11/20. **Fee:** \$15, MD; \$4, others. **Reg. limit:** 200. **Credit:** Category 1, 2 hours; AAFP Prescribed, 2 hours; AOA, 2 hours. **Contact:** Patricia Harrod. **Phone:** 319/359-5401.

### Medicine

**Osteoarthritis**  
For: MD's. Lecture, Nov. 10, 1:00 p.m., North Chicago. **Speaker:** Bruce Rothschild, MD. **Sponsor:** Dept. of Medicine, North Chicago VA Hospital, North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss. **Phone:** 312/942-2965.

### Ophthalmology

**Clinical Conference**  
For: Ophthalmologists. Conference, every Wednesday, Chicago. **Sponsor:** Dept. of Ophthalmology, U of I at the Medical Center, 1855 W. Taylor St., Chicago 60612. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Sharon Russell. **Phone:** 312/996-8023.

### Pathology

**A Practical Approach to Diagnostic Hematologic Problems**  
For: Pathologists, Hematologists, residents in pathology. Workshop, Nov. 10-14, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison, Chicago 60612. **Fee:** yes. **Reg. limit:** 50. **Credit:** Category 1, 30 hours. **Contact:** Administrative Assistant, Educational Center Programs.

### Pediatrics

**Advances in Hepatitis**  
For: MD's. Lecture, Nov. 12, 12:00 noon, Chicago. **Speaker:** Saul Krugman, MD. **Sponsor:** Children's Memorial Hospital, Chicago. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Howard Traisman, MD, 1325 W. Howard St., Evanston 60202. **Phone:** 312/869-4300.

### Pulmonary

**Pediatric Pulmonary Conference**  
For: MD's. Course, Nov. 19, Chicago. **Sponsor:** Chicago Lung Association, 1440 W. Washington, Chicago 60607. **Course Director:** Dharmapuri Vidyasagar, MD. **Phone:** 312/243-2000.

### Radiation Therapy

**New Trends in Radiation Therapy**  
For: MD's. Lecture, Nov. 12, 11:00 a.m., Chicago. **Speaker:** Hebe Forgiione, MD. **Sponsor:** Mertha Washington Hospital, 4055 N. Western Ave., Chicago 60618. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour; AAFP Elective, 1 hour. **Contact:** Rosemary Bradkowski. **Phone:** 312/583-9000 x 332.

### Therapeutics

**Therapeutics II—1980**  
For: MD's, DO's. Lectures/discussion, Nov. 15-16, Madison. **Sponsor:** CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$115. **Credit:** Category 1, 9 hours. **Contact:** Sarah Asleksen. **Phone:** 608/263-2856.



# Special Articles

## *A Longitudinal Study*

### *Physician Attitudes Toward Health Care Policy Issues*

MICHAEL GLASSER, M.A., DENNIS A. FRATE, Ph.D. and KEITH JOHNSON, Ph.D./  
ROCKFORD

*Physicians were surveyed in two northern Illinois counties, Boone and Winnebago, regarding their opinions toward various health policy issues. Changes were monitored by comparing physician responses in 1972 to their responses in 1977. Findings indicate that attitudes had changed dramatically in the five year period, with physicians reacting much more negatively in 1977 than in 1972 to such issues as increased intervention and regulation by both physician-controlled committees and governmental agencies. It is suggested that these findings reflect reaction to legislation passed during the time period and an overriding societal concern with external controls.*

The past decade has witnessed an increase in both actual and proposed regulation of the health care industry. For example, in 1974 the National Health Planning and Resources Development Act was enacted to control duplication of medical services and to contain spiraling costs. In addition to such legislation as Public Law 93-641, there has been mention of numerous other regulatory

actions or reorganization efforts within the medical care sector. Included in these discussions have been mandatory practice locations for newly graduated residents, hospital cost containment legislation, and national health insurance.

Regulation of the medical care industry is a probable outgrowth of increased governmental intervention in many of the private sectors of society including manufacturing and consumer protection. In addition, the rapid growth of both facilities and costs between 1960 and 1975 has contributed toward the move to regulate. Finally, attention given to the "health care crisis" of the 1960's has provided another impetus to intervene in the growth and spread of health care. Whatever the actual reasons behind this trend, it is unique that one sector of society is subject to such review and control from both within and without.

It is within this social environment that we investigated the attitudes of physicians in two northern Illinois counties, Boone and Winnebago, the location of the third largest Standard Metropolitan Statistical Area in Illinois, Rockford. Since attitudes of American physicians toward health care policy issues have usually been characterized as conservative, we were interested both point in time measurements and a longitudinal examination of how their opinions

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**Dennis A. Frate, Ph.D.**, is assistant professor of Health Care Administration, School of Pharmacy, University of Mississippi. Former director of the office for community health research, Rockford School of Medicine, Dr. Frate is an associate fellow of the Sigma XI Council on Epidemiology and member of the American Heart Association.

**Keith Johnson, Ph.D.**, is a former research associate in the office for community health research, Rockford School of Medicine.

changed over time.<sup>1</sup> As a consequence, this study reports the attitudes of physicians toward specific health policy issues in 1972 and in 1977.

### Methodology

Physician attitudes and opinions examined in this article are part of a larger study that was designed to look at characteristics of the physician population practicing in Winnebago and Boone counties. The intent was an understanding of specific characteristics such as physician and practice distribution, demographic variables, and physician opinions in the Rockford vicinity. This information was used, in turn, to examine the role of the Rockford School of Medicine in relation to the already existing local health care delivery system.

An important feature of the original study was its longitudinal design. Any effects of the medical school on the physician population were monitored after a five year interval. Local physicians were surveyed in 1972, immediately after the opening of the school, and again in 1977. In both years, all physicians in Winnebago and Boone counties were sent questionnaires. In 1972, there

was a response rate of 76% (222 physicians) as compared to a response rate of 60% (211) in 1977. Sixty-two percent of the physicians responding in 1972 also responded in 1977.

Focused physician opinions reflect attitudes toward health care delivery in general and reactions to in-house regulation and peer review, governmental intervention, and issues in medical education in particular. Twenty-two statements reflecting these issues were presented to the physicians in both years. Physicians rated their reactions to the statements on a five-point scale, ranging from strong approval to strong disapproval. Comparisons in ratings between the two time periods were made using percentage differences.

### Results

Changes in physician attitudes over the five year period are presented in Table 1. In this table a negative number in the approval column indicates that physician sentiments have changed in the direction of greater disapproval with the statement. Conversely, a negative figure in the disapproval column reflects greater approval with the statement in 1977 than in 1972.

Table 1  
Percentage Differences Between Physician Ratings of Selected Health Care Policy Issues (1972 and 1977)

Statement	Year	Rating*			N
		Disapprove	Neutral	Approve	
( 1 ) Concerted effort by the medical profession to broaden the ambulatory benefits of private health insurance.	1977	3.3	12.4	84.2	209**
	1972	1.3	5.4	91.1	219
		2.0	7.0	- 6.9	
( 2 ) Growth of medically controlled prepaid group practices (multi-specialty).	1977	45.4	36.2	18.3	207
	1972	30.9	27.7	39.2	219
		14.5	8.5	-20.9	
( 3 ) Doctors working on a salaried basis.	1977	64.6	24.4	11.0	209
	1972	55.4	27.7	14.7	219
		9.2	- 3.3	- 3.7	
( 4 ) Doctors working on a fee-for-service basis.	1977	4.3	11.5	84.2	209
	1972	1.3	15.6	80.4	218
		3.0	- 4.1	3.8	
( 5 ) Federal financing for medical care through some system of national health insurance.	1977	65.7	20.8	13.5	207
	1972	51.4	13.8	31.7	217
		14.3	7.0	-18.2	
( 6 ) Increasing the authority of utilization review committees to eliminate unnecessary hospitalization.	1977	31.7	31.3	37.1	208
	1972	15.7	14.7	67.8	220
		16.0	16.6	-30.7	
( 7 ) Peer review of medical work in the hospital.	1977	11.0	27.6	61.4	210
	1972	7.1	9.8	81.3	220
		3.9	17.8	-19.9	

\*Original five category rating scheme has been collapsed into three categories.

\*\*Number of cases varies as a result of missing data.



<u>Statement</u>	<u>Year</u>	<u>Rating</u>			
		<i>Disapprove</i>	<i>Neutral</i>	<i>Approve</i>	<i>N</i>
( 8) Peer review of medical work in the doctor's office	1977	33.5	25.4	41.1	209
	1972	21.9	21.9	54.4	220
( 9) Review of hospital work by physicians from outside one's community.	1977	11.6	3.5	-13.3	
	1972	56.4	25.7	18.1	210
(10) Government grants to newly graduated physicians who agree to practice a certain number of years in medically deficient areas.	1977	45.1	19.6	33.4	220
	1972	11.3	6.1	-15.3	
(11) An accelerated inflow of foreign doctors provided they meet state qualifications.	1977	28.1	29.5	42.4	210
	1972	10.3	13.5	74.9	221
(12) The use of specially trained physicians' assistants who work under the doctor's supervision in his practice.	1977	17.8	16.0	-32.5	
	1972	84.2	11.9	3.8	210
(13) The training of non-physician health associates who work independently to some extent in under-doctored areas	1977	69.3	18.7	10.7	221
	1972	14.9	- 6.9	- 6.9	
(14) Two to three years of general practice as a prerequisite to specialized training.	1977	42.9	34.3	22.8	210
	1972	20.5	25.4	52.8	221
(15) Mandatory area wide planning for capital expansion and specialized needs.	1977	22.4	8.9	-30.0	
	1972	54.3	28.6	17.1	210
(16) More intensive action by physicians and hospitals to sponsor and coordinate health facilities in under-doctored areas.	1977	41.5	23.7	33.5	221
	1972	12.8	4.9	-16.4	
(17) Comprehensive Health Planning as the agency for area wide coordination of health care and facilities.	1977	50.9	21.0	26.7	210
	1972	34.8	17.9	45.5	220
(18) Medical students should be exposed to patients from the very beginning of their medical education.	1977	16.1	3.1	-18.8	
	1972	36.5	26.4	37.0	208
(19) Most medical training is better left to full time faculties rather than to practicing physicians.	1977	14.2	25.9	56.8	217
	1972	22.3	.5	-19.8	
(20) Medical schools should vigorously pursue research in new methods of delivering care to community residents.	1977	10.1	29.3	60.6	208
	1972	5.8	20.1	72.3	220
(21) Comprehensive medical care groups such as the urban or rural poor should be handled by private physicians rather than by medical schools or other public facilities.	1977	4.3	9.2	-11.7	
	1972	46.2	19.2	24.8	206
(22) One of the major goals of medical education should be to instill in medical students the importance of cooperation with the dependence upon members of other health professions and sub-professions.	1977	12.4	35.3	48.7	216
	1972	33.8	- 6.2	-23.9	
(23) Medical schools should expose students to patients from the very beginning of their medical education.	1977	31.2	19.0	49.7	211
	1972	21.9	14.7	62.4	222
(24) Most medical training is better left to full time faculties rather than to practicing physicians.	1977	9.3	4.3	-12.7	
	1972	59.8	25.1	15.2	211
(25) Medical schools should vigorously pursue research in new methods of delivering care to community residents.	1977	60.7	18.3	18.8	219
	1972	- .9	6.8	- 3.6	
(26) Comprehensive medical care groups such as the urban or rural poor should be handled by private physicians rather than by medical schools or other public facilities.	1977	27.6	36.7	35.8	210
	1972	14.2	20.2	64.3	221
(27) One of the major goals of medical education should be to instill in medical students the importance of cooperation with the dependence upon members of other health professions and sub-professions.	1977	13.4	16.5	-28.5	
	1972	20.9	49.0	30.0	210
(28) One of the major goals of medical education should be to instill in medical students the importance of cooperation with the dependence upon members of other health professions and sub-professions.	1977	29.4	36.5	32.3	220
	1972	- 8.5	12.5	- 2.3	
(29) One of the major goals of medical education should be to instill in medical students the importance of cooperation with the dependence upon members of other health professions and sub-professions.	1977	12.1	22.1	65.9	208
	1972	12.2	21.9	64.3	218
(30) One of the major goals of medical education should be to instill in medical students the importance of cooperation with the dependence upon members of other health professions and sub-professions.	1977	- .1	.2	1.6	
	1972				

It is immediately obvious that in nearly all instances physician sentiment has moved from approval, whether moderate or strong, to neutrality and disapproval. In only four cases has physician sentiment remained unchanged or moved slightly in a positive direction. For instance, physicians in 1977 generally agree with the statement that doctors should work on a fee-for-service basis; similarly, they agree that medical education should stress to students the importance of cooperation with other health professionals.

On the other hand, physicians in 1977 overwhelmingly express greater disapproval with statements implying control, regulation, and review than do physicians surveyed in 1972. This is true whether regulation comes from outside, as from governmental controls, or from within, as in the cases of peer and hospital reviews. In general, the physicians in 1977 were *less likely to agree that* the medical profession should broaden the ambulatory benefits of private insurance, doctors should work on a salaried basis, medical and hospital work should be reviewed by peers, there should be more foreign-trained physicians, physicians and hospitals should be more active in sponsoring and coordinating health facilities in under-doctored areas, medical students need two to three years of general practice before special training, and medical students need exposure to

patients early in their careers.

More volatile issues, yet, as reflected in the very large percentage differences between the two time periods, are the following: negative reaction to the idea of federally financed national health insurance, opposition to utilization review in hospitals, disapproval of the need for government grants as incentives to physician location, questioning of being told to use physician assistants and health associates, strong disapproval of control through area-wide planning and comprehensive health planning, and disagreement that medical schools must vigorously pursue research in new methods of health care delivery to community residents. In general, physician sentiment appears to have moved toward disapproval of most intervention that dictates what the profession of medicine "should" be doing.

While the evidence presented here points to an overall trend toward negative reaction to controls and dictation of policy, an interesting related issue is the extent to which physician priorities have changed over the five year interval. That is, while there has been change in the direction of greater disapproval, have physician rankings of the issues they most disapprove and approve of, also, changed in this time period? To examine this, the categories of strong disapproval through strong approval were assigned values of one through five. Means were computed for each

Table 2  
Comparisons of Relative Rankings of Statements  
Between 1972 and 1977, Based on Mean Scores

Statement	1972*	1977
More foreign-trained MDs	1	1
MDs on salary	2	3
Medical training left to full-time faculty	3	4
Federal financed National Health Insurance	4	2
Review of hospital work by outside MDs	5	5
MD health associates	6	6
Growth of multispecialty group practice	7	8
Private MDs, not public facilities handle care	8	15
2-3 years of general practice before special training	9	7
Use of MD assistants	10	10
Medical education should stress cooperation with non-MDs	11	20
Peer review of medical work in MD office	12	13
CHP as coordinating agency	13	9
Area wide planning	14	12
Medical students exposed to patients early	15	17
More utilization review in hospitals	16	11
Medical schools should research new care methods	17	14
Government grants to MDs moving to deficient areas	18	16
More action for facilities in under-doctored areas	19	18
Peer review of medical work in hospitals	20	19
MDs fee-for-service	21	21
Broaden ambulatory benefits	22	22

\*Scores are ranked from strongest disapproval to strongest approval.



statement; the statements were then ordered from strongest disapproval to strongest approval based on these means. These rankings for 1972 and 1977 are presented in Table 2.

These results indicate a very strong consistency between physician attitudes for the two years. While degree of disapproval and approval has shifted fairly substantially, ranking of one issue relative to another has not. Physician priorities on these health policy issues are very similar. As a matter of fact, Spearman's rho for the two sets of rankings is equal to .844, indicating a strong relationship between the 1972 and 1977 rankings.

### Conclusion

Physicians have generally been characterized as having rather conservative opinions, especially in regard to health care policy issues. Such characterizations almost always imply a rather static outlook. Although providing some confirming evidence of the overall conservative appraisals by physicians on various health policy matters, this study found that attitudes of physicians were quite dynamic, changing dramatically between 1972 and 1977. In addition to the fact that their opinions altered, the direction of change is worthy of note: the five year period between measurement was marked by an increase in nega-

tive sentiment toward the majority of health policy matters listed. The overall ranking of the health policy issues remained fairly consistent between 1972 and 1977; nevertheless, there was a considerable shift toward negative evaluation of these issues.

The explanation for these findings is not entirely clear. The use of two specific years, 1972 and 1977, may be especially significant since many organizational changes and health policy issues were suggested during that particular five year period. Therefore, physicians may be judging the impact of those policy changes already enacted and assessing those changes on experience. Also, our society has been recently witnessing an ever increasing movement against governmental intervention in many phases of life. Medical care, like any other social sphere, does not exist in isolation from the larger society. Thus, the data presented here probably do not merely represent a movement within one occupational group but rather offer a reflection of societal changes in general. ◀

### References

1. Colombotos, John, Charles, Catherine A., and Kirchner, Corinne.: "Physicians' Attitudes Toward Political and Health Care Policy Issues in Cross-National Perspective: A Comparison of FMGs and USMGs," *Social Science and Medicine*, 11:603-609, 1977.

## ISMS Travel Programs 1981

The following ISMS-sponsored travel programs have been scheduled for 1981:

January 28 - February 11—SOUTH AFRICA (Johannesburg/Cape Town/Plettenberg Bay/Durban)

February 18 - February 25—Hawaii (an additional one week optional trip to the outer islands is available)

June 30 - July 12—Rhine/Alpine (Mainz, West Germany; Lucerne, Switzerland, Innsbruck, Vienna, Austria, and Salzburg, Austria)

July 26 - August 6—British Isles (Ireland, Scotland, England)

August 7 - August 16—Canadian Rockies (Vancouver, Banff, Lake Louise and Jasper)

August 29 - September 12—Alaska Cruise (San Francisco, Vancouver, Ketchikan, Juneau, Glacier Bay, Sitka, and Victoria)

September 9 - September 21—Italy (Naples, Rome, Florence, Venice, Capri and Sorrento)

Reservations cannot be accepted without the official form printed in promotional brochures, which will be mailed to all ISMS members and auxiliary at least five months in advance. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by tour operators. For further information, please contact ISMS headquarters.

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**Dosage and Administration:** Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol-HC Suppositories.

**Anusol-HC Cream — Adults:** After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

**NOTE:** If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

**How Supplied:** Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C). Full information is available on request.

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# IMJ

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## ISMS ORGANIZATION

### History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers

given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

# Principles of Medical Ethics

**Preamble:** The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

**I.** A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

**II.** A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

**III.** A physician shall respect the law and also recognize a responsibility

to seek changes in those requirements which are contrary to the best interests of the patient.

**IV.** A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

**V.** A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

**VI.** A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

**VII.** A physician shall recognize a responsibility to participate in activities contributing to an improved community.

*Adopted by the American Medical Association House of Delegates July, 1980*



# ILLINOIS STATE MEDICAL SOCIETY

## Constitution And Bylaws

**Adopted, 1903  
As Amended, 1980**

### CONSTITUTION

#### ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

#### ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

#### ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

#### ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

#### ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State

Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

#### ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

#### ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

#### ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

#### ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

#### ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

### BYLAWS

#### CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principal-

ly in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

**B. Emeritus Members.** Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

**C. Retired Members.** Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

**D. Service Members.** Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

**E. Distinguished Members.** Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

**F. In-Training Members.** In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members, of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

**G. Student Members.** Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

**Section 2. Discrimination of Membership.** Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

### Section 3. Tenure and Termination.

**A. Tenure of Membership.** The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so

long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

**B. Termination of Membership.** Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have lapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

## CHAPTER II. DUES, FUNDS AND ASSESSMENTS

**Section 1. Dues.** Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

**Section 2. Reduction and Remission of Dues.** Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

**Section 3. Assessments and Funds.** In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and ap-



proved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

### CHAPTER III.

#### EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

### CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section and 9) one delegate elected by the Student Business Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* There shall be a Resident Physicians Section and a Student Business Section, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meetings.* The House of Delegates shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11b of this Chapter. The interim meeting should be held in a district other than where the annual meeting is held.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special Meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary

shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called. Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11a. *Introduction of Resolutions and Other Business at the Annual Meeting.* All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only. A full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters four weeks prior to the annual or interim meeting. Resolutions received after the above date, except those originating from the RPS and SBS business sessions, must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Resolutions presented from the business meeting of the Resident Physicians Section or the Student Business Section may be presented for consideration by the House of Delegates at any time before the close of business the first day session of the House of Delegates.

Section 11b. *Introduction of Resolutions and Other Business at the Interim Meeting.* The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.



2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.

3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Student Business Section which are considered urgent and accepted by the Committee on Rules and Order of Business.

4. Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. *Judicial Panel.* The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

#### CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elect-

ed and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

#### CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions and shall serve as its spokesman. He defends the Constitution and Bylaws, interprets the policies established by the House of Delegates, and works to preserve the unity of the Society. He serves as a member of the Board of Trustees and maintains liaison with the Chairman of the Board and Executive Administrator. He is a member of the Board of Directors of the Educational and Scientific Foundation. He inducts the incoming President and delivers a report annually to the House of Delegates. Upon completion of his term as President, he becomes the immediate Past President and serves one year on the Board of Trustees as Trustee-at-Large. He may delegate any of his duties.

Section 2. *The President-Elect.* The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.



The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

**Section 8. Delegates and Alternate Delegates to the American Medical Association.** Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

## CHAPTER VII. THE BOARD OF TRUSTEES

**Section 1. Composition.** The Board of Trustees shall consist of: twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

**Section 2. Duties.** The duties of the Board of Trustees are executive and custodial.

**A. Executive Duties.** The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

**B. Custodial Duties.** The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

**Section 3. Executive Administrator.** The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

**Section 4. Meetings.** The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

**Section 5. Organization.**

**A. Chairman.** The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

**B. Duties of the Chairman.** The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors



execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. *Quorum.* Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it

may deem necessary.

## CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

## CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. Committees Reporting Directly to the Board of Trustees
- C. House of Delegates Committees
- D. Board of Trustees Committees

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:

1. Liaison with the Illinois Bar Association
2. Liaison with courts, particularly where impartial medical testimony is involved.
3. Implementation of the Impartial Medical Testimony Rule
4. Legal aspects of medical practice other than in the area of mental health
5. Licensing and standards of practice
6. Quackery
7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:

1. Federal and state legislation—analysis and communication
2. Legislative liaison—both state and federal
3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:

1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Internships, residencies, etc.
4. Scientific assembly
5. Student loans



6. Liaison with American Medical Student Association
7. Continuing Medical Education

D. The Council on Economics shall be concerned in the areas of:

1. Ongoing relationships with third parties
2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:

1. The provision of medical care and health services in the public and private sectors
2. Emergency medical services
3. Health care of the poor, aged and those in rural areas
4. Maternal and child health
5. Nutrition
6. Workmen's compensation
7. Environmental and community health
8. Rehabilitation
9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:

1. Publicity and promotion
2. News media relations
3. Exhibits and public service programming
4. Religion and medicine
5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:

1. Facilities and services
2. Liaison with Department of Mental Health
3. Legal aspects of commitment, etc.
4. Narcotics and dangerous drugs
5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:

1. Liaison between the affiliate society and ISMS
2. Scientific resource information and advice to ISMS
3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation
4. Advances of medical science in special fields
5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society

### Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the

Governing Council of the ISMS Student Business Section and resident physician members nominated by the Governing Council of the ISMS Resident Physicians Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

### J. Affiliate Societies

1. *Qualifications.* Affiliate societies shall be those rec-

ognized societies of Illinois

- a) as may be approved by the Board of Trustees
- b) which desire representation on the Council on Affiliate Societies

- 2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

#### Section 4. *Committees Reporting Directly to the Board of Trustees*

- A. *Planning and Priorities Committee.* This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-elect shall serve as chairman of the committee.
- B. *Committee on Insurance.* This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.
- C. *Committee on Health Planning.* The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain ongoing liaison with the State Health Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.
- D. *Committee on Drugs and Therapeutics.* The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.
- E. *Health Data Committee.* The committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of PSROs, HSAs, the Illinois Cooperative Health Data System (ICHDS), governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees, and other appropriate persons within ISMS advised on the data collection matters.
- F. *Peer Review Appeals Committee.* This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves

the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.

- G. *Committee on CME Accreditation.* It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decision on grant of initial accreditation and continuation of accredited status.

#### Section 5. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

- A. *Committee on Credentials* shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.
- B. *Committee on Rules and Order of Business* shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.

It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.
- C. *Committee on Tellers and Sergeants-at-Arms* shall:
  - 1. Serve the speaker of the House of Delegates.
  - 2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
  - 3. Certify those in attendance in closed or executive sessions of the House of Delegates.
- D. *Committee on Changes in the Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.
- E. *Ad hoc committees* may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.
- F. *Such other reference committees* as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

#### Section 6. *Organization of House of Delegates Committees.*



- A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

- B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.
- C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 7. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

- A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past-chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

- B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

- C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

- D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

- E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

- F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

- G. The Committee on Third Party Payment Processes shall consist of members of the Board of Trustees and be activated whenever an issue or problem requires high level negotiations between ISMS and third-party payors.

- H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 8. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 9. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.



## CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in

which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon members of the component societies.

## CHAPTER XI. ETHICAL RELATIONS PART 1. COMPONENT MEDICAL SOCIETY

Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings*.

## PART 2. DISTRICT ETHICAL RELATIONS COMMITTEE

The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee, serving its area, function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relations Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

## PART 3. OFFENSES

A. Disciplinary action may be taken against any member of a component society when:

1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
2. He has been adjudged or otherwise recorded as guilty by his component society of:
  - a. acts of serious misconduct as a physician; or
  - b. a violation of the Constitution or Bylaws of his component society, or of the Principles of Medical Ethics promulgated by the American Medical Association; or
3. He has been judged guilty of a violation of a law



or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

#### PART 4. STANDARDS AND PROCEDURES

- A. The committee, in its deliberations, shall evaluate acts by the standards established in the Principles of Medical Ethics of the American Medical Association and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.
- B. Disciplinary action may be initiated by the component society or the Illinois State Medical Society upon receipt of formal written charges filed by a licensed physician practicing or residing in the State of Illinois alleging violations of any of the offenses enumerated in this Part 3. Written charges received by the Illinois State Medical Society shall be referred to the Secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

#### PART 5. PENALTIES

The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership. A decision based on a recommendation to acquit shall be final and not appealable.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and all privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to his expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

#### PART 6. DECISION BY COMPONENT MEDICAL SOCIETY

- A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsidera-

tion. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

- B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

#### PART 7. JUDICIAL PANEL

A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an ini-



tial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs because of illness, death or resignation of a member or for any other reason, the President of the Illinois State Medical Society shall nominate a successor who shall serve by appointment of the Board of Trustees until the next meeting of the House of Delegates. At the meeting of the House of Delegates next occurring after the interim appointment has been made, the nominee then temporarily serving to fill the vacancy may be elected by the House of Delegates to an appropriate term, in accordance with provisions of these bylaws.

In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees.

The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as is necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings*, to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

## PART 8. DUE PROCESS SAFEGUARDS

In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

## CHAPTER XII PEER REVIEW PART 1—DEFINITIONS

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient

relations issues. Medical Society peer review shall be conducted at the local level whenever possible. Ethical relations issues identified during deliberations of the Peer Review Committee shall be appropriately referred. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

## PART 2—COMPONENT SOCIETY PROCEDURES

- A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.
- B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.
- C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.
- D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component Society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review the decision of the component Society; except that a petition must set forth any one of the following grounds as a basis for the appeal:
  1. **PROCEDURAL ERROR**—The peer review proceeding was not conducted in accordance with rules established by the component Society or the Illinois State Medical Society.
  2. **BIAS**—The proceeding was conducted in a biased or arbitrary manner.
  3. **INCOMPLETE INFORMATION**—If information not available to the component Society is submitted to the State Peer Review Appeals Committee, the Committee will first determine the relevancy of the new information. The case will be referred to the component Society for reconsideration if the infor-



mation is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

#### PART 3—DISTRICT COMMITTEE

The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

#### PART 4—ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

A. There shall be created a Peer Review Appeals Com-

mittee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

The Peer Review Appeals Committee shall review decisions of component or District Peer Review Committees accepted on appeal, in accordance with the provisions of Part 2 (D) of this Chapter. The state committee shall act to affirm, reverse, modify, or remand to the local or district committee such decision. The state Committee shall have the authority to assign cases to District Peer Review Committees in accordance with Part 3 of this Chapter. Decisions of the State Committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

#### CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

#### CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

#### CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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# 1980-1981

## Policy Manual

### of the

# Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its

next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request



Board consideration at any time.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of

Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

## PROFESSIONAL POLICIES

### Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement. (Amended, 1980 Annual Meeting)

### Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists. (1975 Annual Meeting—Reviewed by Board 1980)

### Advertising Guidelines, Physician Professional

In keeping with the Principles of Medical Ethics, as well as rules of law, the following advertising guidelines are adopted:

#### I. General

These guidelines shall apply to solo practitioners and groups of physicians, including medical clinics, HMOs, and other physician-operated facilities. The medical society recommends that these guidelines be suggested for hospitals and other health care institutions. The medical society does not look with favor upon advertisements which promote or produce unfair competition.

#### II. Acceptable Professional Identification

1. Name, with earned degree(s)
2. Office address and telephone
3. Home address and telephone
4. Answering service
5. Office hours
6. Medical specialization
7. Board certification
8. Type of practice (group, solo) and affiliation, so long as such identification is not misleading
9. Hospital affiliation
10. Foreign language competence
11. Usual and customary fees, for routine medical service. Such fee identification must include notification that fees may be adjusted in the event that complications or unforeseen circumstances arise. The usual and customary fee quoted shall be that fee charged to the majority

of patients seeking the same basic service. Such fee identification must not be misleading. Average charges may not be stated.

12. Public announcement of changes in any of the above

#### III. Professionally Unacceptable

1. Testimonials or anecdotal reports of medical practice successes
2. Claims of superior quality of care
3. Fee comparisons of available services with those of other licensed physicians or medical clinics
4. Listing of professional service which the offerer is not qualified to provide
5. Statements which contain false, fraudulent, deceptive or misleading material
6. Warranties or guarantees of success or unsuccessful therapy
7. Statements which play upon the fears and vanities of the public
8. Display or similar advertising that may serve to mislead or misinform the public
9. Solicitation of media coverage of medical services by means of "news stories" designed for personal or financial gain

#### IV. Media Guidelines

1. Newspapers and magazines
    - a. Type size shall be that text type used in the publication
    - b. Use of any ornaments, embellishments, or symbols is prohibited
  2. Professional or business cards, and office signs giving allowable information are permissible
  3. Health care services directories (including telephone directories) are subject to the same policies as stated under newspapers and magazines above
- (1979 Annual Meeting)

### Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics. (Amended, 1980 Annual Meeting)

## **Alcoholism Education**

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socio-economic impacts, should be encouraged. (Amended, 1980 Annual Meeting)

## **Ambulance Services**

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards. (Amended, 1980 Annual Meeting)

## **Assessments**

Medical Staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds or other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments. (Amended, 1980 Annual Meeting)

## **Athletic Programs**

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential. (Prior to 1965)

## **Audits & Surveys**

### **(Hospital, nursing homes, etc.)**

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned. (1968 Annual Meeting)

## **Autopsies, Declining Number of**

Because the autopsy has educational benefits for medical science as well as the family of the deceased individual, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death. (1978 Annual Meeting)

## **Birth Control**

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods. (Reviewed, 1980)

## **Blood Availability**

The Illinois State Medical Society encourages component societies to support abolition of blood bank replacement deposit fees (often referred to as penalty or non-replacement fees).

The Illinois State Medical Society and its component

societies encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state. (1979 Annual Meeting)

## **Blood Procurement**

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

(1971 Annual Meeting)

## **Confidentiality**

Communications received in confidence by physicians from patients are privileged; the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics states that "A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of the confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient confidential relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in opposition to the use of the Social Security number as a universal number identifier. (Amended, 1979 Interim Meeting)

*Note:* Section 9 eliminated and reference to confidentiality altered in revised Principles of Medical Ethics adopted by AMA House of Delegates July, 1980.

## **Continuing Education**

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS should continue to support the efforts of county medical societies in becoming certified for sponsoring continuing medical education programs meeting the requirements promulgated by the AMA Committee on Accreditation of Continuing Medical Education and the regulations of the State of Illinois.

Financial support for ICCME is provided by the Board of Trustees of ISMS, based upon the needs as determined by the ISMS Finance Committee, such needs to include provisions for contingencies. To each annual meeting of the House of Delegates an annual financial report, indicating (a) major sources of income and (b) major categories of expenditure for the year preceding, plus a copy



of the budget adopted by the ICCME Board for the year in which the House is meeting, will be submitted.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. (1978 Interim Meeting)

### Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.

(1978 Interim Meeting)

### Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians. (1977 Annual Meeting)

### Death, Legal Definition of

ISMS will not support any legislative proposal which seeks to define death unless it provides that, based upon usual and reasonable standards of medical practice, death has occurred when it is determined by a doctor of medicine that a person has experienced the permanent and irreversible cessation of the integrated functioning of the respiratory, circulatory and nervous system, according to the following standards:

- The irreversible cessation of spontaneous respiratory and circulatory functions; or
- if artificial means of support preclude reliance on

item (a), the irreversible cessation of spontaneous brain function, which may be confirmed by a flat (isoelectric) electroencephalographic tracing in the absence of hypothermia and of barbiturate and other nervous system depressants.

(1977 Annual Meeting)

### Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based on what must necessarily be a private matter between physician and patient.

(1977 Annual Meeting)

### Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.

(Amended, 1980 Annual Meeting)

### Discrimination—(see "Freedom of Choice") Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

(1976 Interim Meeting)

### Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.

(1976 Annual Meeting)

### Emergency Medical Care, Provision of

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

(1980 Annual Meeting)

### Ethics

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.

(1979 Interim Meeting)

### Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.  
(1966 Annual Meeting—Reviewed by Board 1980)

### **Experimental Medical Procedures**

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

(1973 Annual Meeting)

### **Eyes**

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.

(1976 Annual Meeting—Reviewed by Board 1980)

### **Foundations for Medical Care**

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a statewide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.

(1977 Interim Meeting)

### **Freedom of Choice**

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right

of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.

(1976 Interim Meeting)

### **Fund Solicitation by Persons Affiliated with Health Systems Agencies**

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.

(1980 Annual Meeting)

### **Governmentally Supported Health Facilities**

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.

(1978 Annual Meeting)

### **Health Care—Ancillary Services**

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

(1973 Annual Meeting)

### **Health Care Costs**

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.

(1977 Interim Meeting)

### **Health Careers**

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

(1967 Annual Meeting—Reviewed by Board 1980)



## Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.

(Amended, 1979 Interim Meeting)

## Health Insurance, Voluntary Plans

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for out-patient diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physician's charges above insurance benefit allowances are excessive;

- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;

- Suggesting that physicians perform alternative surgical procedures;

- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;

- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and

- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1979 Interim Meeting)

## Health Planning

ISMS urges physician participation in the health planning process at all levels, with strong emphasis on planning at the local community level. ISMS supports health planning at the local level, and opposes centralized health planning.

(1980 Annual Meeting)

## Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

(1974 Annual Meeting—Reviewed by Board 1980)

## Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.

(1977 Annual Meeting)

## Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

All county medical societies are encouraged to form standing committees composed of medical society officers and representative officers of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

(1977 Annual Meeting)

## Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

(1978 Annual Meeting)

### Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the Bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society supports physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.

(1980 Annual Meeting)

### Hospital Records and Their Availability

Patient care hospital records contain privileged information of confidential nature. Such records are the property of the hospital; information contained therein is held in trust, through a fiduciary relationship, by the hospital.

Patients, and upon appropriate, written authorization, their attorney or succeeding physician, have the right of access to these records, with the ability of review and the right to copy or receive copies. This access is not afforded to patients in cases of psychiatric illness.

Upon receipt of proper, written authorization from the patient, a copy, abstract or summary shall be provided as required, to insurance companies, governmental agencies, or other hospitals.

Patient records utilized by official committees of organized medical staffs to accomplish scientific studies of morbidity or mortality, utilization review, peer review or other patient care improvement activity remain confidential and shall not be disclosed to any person outside the purview of such committees.

Where litigation is involved, a physician may be required to release medical records in the absence of a signed patient authorization. In those instances, a physician should ascertain that he is required to release the medical records and that the agent so requiring the release has the appropriate authority.

(1976 Interim Meeting)

### Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection, especially to all children, or to encourage the local public health agency to perform this function.

Every school district should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

County medical societies should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact

either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.

(1976 Interim Meeting)

### Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

(Prior to 1965—Reviewed by Board 1980)

### Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

(Prior to 1965)

### Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.

(1976 Annual Meeting—Reviewed by Board 1980)

### Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.

(Amended, 1980 Annual Meeting)

### Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

The Illinois State Medical Society favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

(Amended, 1980 Annual Meeting)



## Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

(1971 Annual Meeting—Reviewed by Board 1980)

## Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.

(1979 Annual Meeting)

## Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.

(Amended, 1980 Annual Meeting)

## Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness must satisfy the definition of an expert witness, that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.

(1977 Annual Meeting)

## Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

(Amended, 1980 Annual Meeting)

## Mental Health

The Illinois State Medical Society strongly opposes a double standard of care in state hospitals.

The Department of Mental Health and Developmental Disabilities should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.

2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.

3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.

4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches, and a physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

(1977 Annual Meeting)

## Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

(1972 Annual Meeting)

## Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

(1970 Annual Meeting—Reviewed by Board 1980)

## Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

(1973 Annual Meeting—Reviewed by Board 1980)

## Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.

(Amended, 1980 Annual Meeting)

## Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

(Prior to 1965)

## Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities

should be directly responsible to their respective departments of ophthalmology.  
(1978 Annual Meeting)

### **Osteopaths, Association with**

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

(1968 Annual Meeting)

### **Peer Review**

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical society peer review shall be conducted at the local level whenever possible. Major ethical relations questions identified during deliberations of the Peer Review Committee shall be appropriately referred.

(1978 Interim Meeting)

### **Physician Records, Privacy of**

The Illinois State Medical Society will take whatever action is necessary to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.

(1978 Interim Meeting)

### **Physicians**

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches." The goal of the Illinois State Medical Society is to have this definition made a part of the Illinois Medical Practice Act.

(1977 Annual Meeting)

### **Physician's Assistants**

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.

(1980 Annual Meeting)

### **Prolonging Human Life**

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.

(1976 Annual Meeting)

### **Psychosurgery**

Psychosurgery refers to those surgical operations which

irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.

(1975 Annual Meeting—Reviewed by Board 1980)

### **Public Aid**

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and co-operating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

An extensive program of education and rehabilitation should be conducted for the recipients of public aid.

Rehabilitation of all recipients should be of paramount concern.

(1978 Interim Meeting)

### **Public Health Departments**

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.

(Amended, 1980 Annual Meeting)

### **Public Safety**

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

(Prior to 1965)



## Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

(Prior to 1965—Reviewed by Board 1980)

## Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.

(1980 Annual Meeting)

## Reimbursement for Out-Patient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.

(1980 Annual Meeting)

## Relationship with Third-Party Payors

ISMS should provide guidance, education, communications, and negotiations between the membership and third-party payors.

(1980 Annual Meeting)

## Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Physicians and their employees should refrain from smoking during patient contacts.

Physicians should give advice and provide literature and signs concerning the health hazards of smoking.

ISMS encourages and supports efforts, legislative and otherwise, to ban or restrict smoking in all public places and the development of appropriate regulations to accomplish this.

(Amended, 1979 Interim Meeting)

## Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.

(1979 Annual Meeting)

## Surgery, Reconstructive

Surgery to correct post-surgical deformities is reconstructive surgery.

(1979 Annual Meeting)

## Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.

(1979 Annual Meeting)

## Third Party Intrusion Into Medical Judgment

Medical judgement and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician.

(1978 Annual Meeting)

## Usual and Customary or Reasonable Reimbursement

The Illinois State Medical Society endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule.

(1979 Annual Meeting)

## Utilization Review

ISMS encourages hospital medical staffs to perform focused utilization review of all patients in selected diagnostic categories, regardless of the source of payment.

ISMS urges all third party payors—private insurance carriers as well as government—to provide reimbursement to hospitals and physicians for time and expense incurred in focused utilization review.

(1978 Interim Meeting)

## Veterans Administration

The Illinois State Medical Society continues to support the concept that a Veterans Administration hospital should only be concerned with the needs of those patients with service-connected disabilities.

(Amended, 1980 Annual Meeting)

## Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.

(1978 Annual Meeting)

## ADMINISTRATIVE POLICIES

### AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.  
(1971 Annual Meeting)

### Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.  
(1967 Annual Meeting)

### Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.  
(Prior to 1965)

### Budgets—(see "Financial Policies")

### Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.

(1978 Interim Meeting)

### Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.  
(Prior to 1965)

### Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates.  
(1980 Annual Meeting)

### Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.

(Amended, 1980 Annual Meeting)

### Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for election as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

(1977 Annual Meeting)

### Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.

(1978 Annual Meeting)

### IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings

It should be requested of authors or discussants that original papers presented before programs for which ISMS has primary fiscal sponsorship be submitted to the *Illinois Medical Journal* for publication consideration and the right of acceptance or refusal.

(1978 Interim Meeting)



## Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.

(Prior to 1965—Reviewed by Board 1980)

## Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal*;
2. Brief notice in Action Report, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(1977 Annual Meeting)

## ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

(Prior to 1965—Reviewed by Board 1980)

## ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils and committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except in situations wherein positions suddenly become open, and such consultation is impossible.

(1976 Interim Meeting)

## Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

(Prior to 1965)

## Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Board of Trustees.

(Amended, 1980 Annual Meeting)

## Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

(1971 Annual Meeting—Reviewed by Board 1980)

## Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

(1974 Annual Meeting—Reviewed by Board 1980)

## Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.

(Amended, 1980 Annual Meeting)

## Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.

(1978 Interim Meeting)

## Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the

health and welfare of the residents of Illinois.  
(Prior to 1965)

## Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.  
(1970 Annual Meeting)

## Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.  
(1980 Annual Meeting)

## Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.  
(1976 Interim Meeting)

## Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)  
(Prior to 1965)

## Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the

professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for his liability coverage.

The Illinois State Medical Society should protect the interests of its members by encouraging the provision of a guarantee of due process in the bylaws of the Illinois State Medical Inter-Insurance Exchange.

(1975 Annual Meeting)

## Public Statements

Only officially designated persons may publicly speak for the society. The Chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the Society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the Society's policies and positions.

(1978 Annual Meeting)

## Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.

(1980 Annual Meeting)

## Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, and the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

(Prior to 1965)

## Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

(1967 Annual Meeting)

## Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

(Prior to 1965)

## Resident Participation at County Level

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.

(1980 Annual Meeting)



## **Resident-Student Alternate Delegates to AMA**

The Resident Physicians Section and the Student Business Session shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.  
(1979 Annual Meeting)

## **Resolutions**

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.  
(1976 Interim Meeting)

## **Surveys**

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.  
(Prior to 1965)

## **Uniform Health Insurance Claim Form**

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.

(1974 Annual Meeting—Reviewed by Board 1980)

# **Policy Manual**

## **APPENDIX**

### **Multiphasic Health Testing Council on Environmental and Community Health Statement**

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status.

Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring

patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic

health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

### AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians must be involved in the planning and development of testing programs.
4. The operation of all MHT programs must be supervised by qualified physicians at the testing center, particularly in regard to any abnormal findings, and these physicians must see that the patient is instructed to obtain medical advice for significant abnormal findings.
5. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
6. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity,

specificity, high predictive value, and patient acceptance.

7. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
8. The program should provide for confidentiality of patient data.
9. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
10. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
11. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
12. The program should maintain freedom of choice for both the physician and the patient.

### Statement of Understanding

*(between patient and physician)*

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit

any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.



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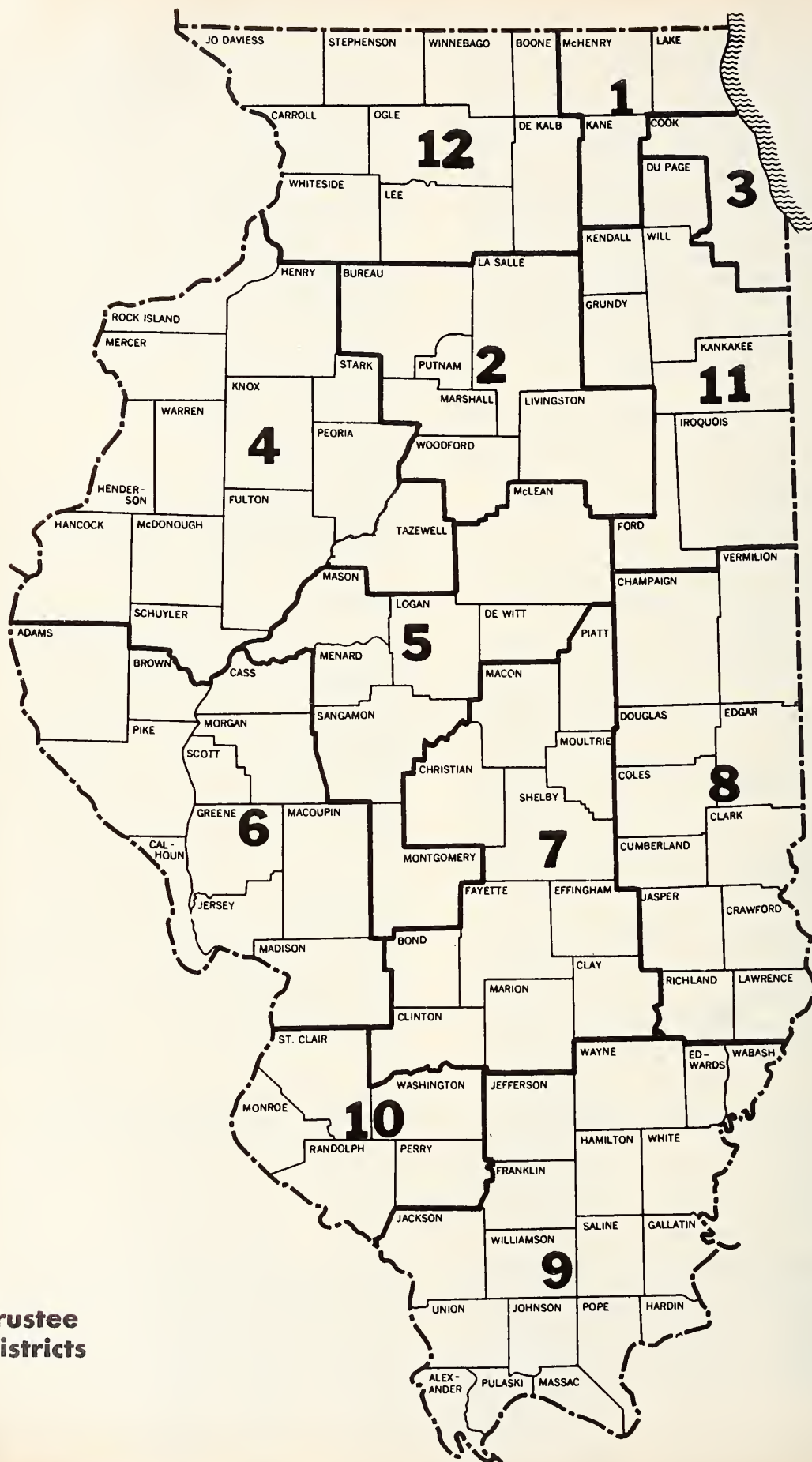
Walter C. Bornemeier, Chicago .....1962-1964  
Edward W. Cannady, Belleville .....1965-1967  
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Paul W. Sunderland, Gibson City .....1971-1973  
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PEER REVIEW COMMITTEE	
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	TERM EXPIRES
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ETHICAL RELATIONS COMMITTEE	
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Jerry Ramunis, Victoria .....	1982

PEER REVIEW COMMITTEE	
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PEER REVIEW COMMITTEE	
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C. B. Lara, Pittsfield .....	1981
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PEER REVIEW COMMITTEE	
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Robert C. Murphy, Quincy .....	1982
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James Sutherland, Quincy .....	1983
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ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
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C. R. Daisy, Greenville .....	1981
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I. Del Valle, Taylorville .....	1982

#### PEER REVIEW COMMITTEE

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James H. Pass, Olney .....	1981
R. R. Manson, Urbana .....	1982
Stanley R. Huffman, Charleston .....	1983

#### PEER REVIEW COMMITTEE

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Robert Rader, Anna .....	1983

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Charles K. Wells, Mt. Vernon .....	1982

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Edilberto Maglasang, Columbia .....	1982
Wm. A. Simmons, Belleville .....	1982

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Benjamin Arenas, Belleville .....	1982
Ted Bryan, Belleville .....	1982
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R. E. Schettler, Red Bud .....	1983
Ron Welch, Belleville .....	1981

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Merle Otto, Frankfort .....	1982
William C. Perkins, West Chicago .....	1982

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W. H. Brill, Oswego .....	1983
Charles G. White, Naperville .....	1982
Alex Spadoni, Joliet .....	1982

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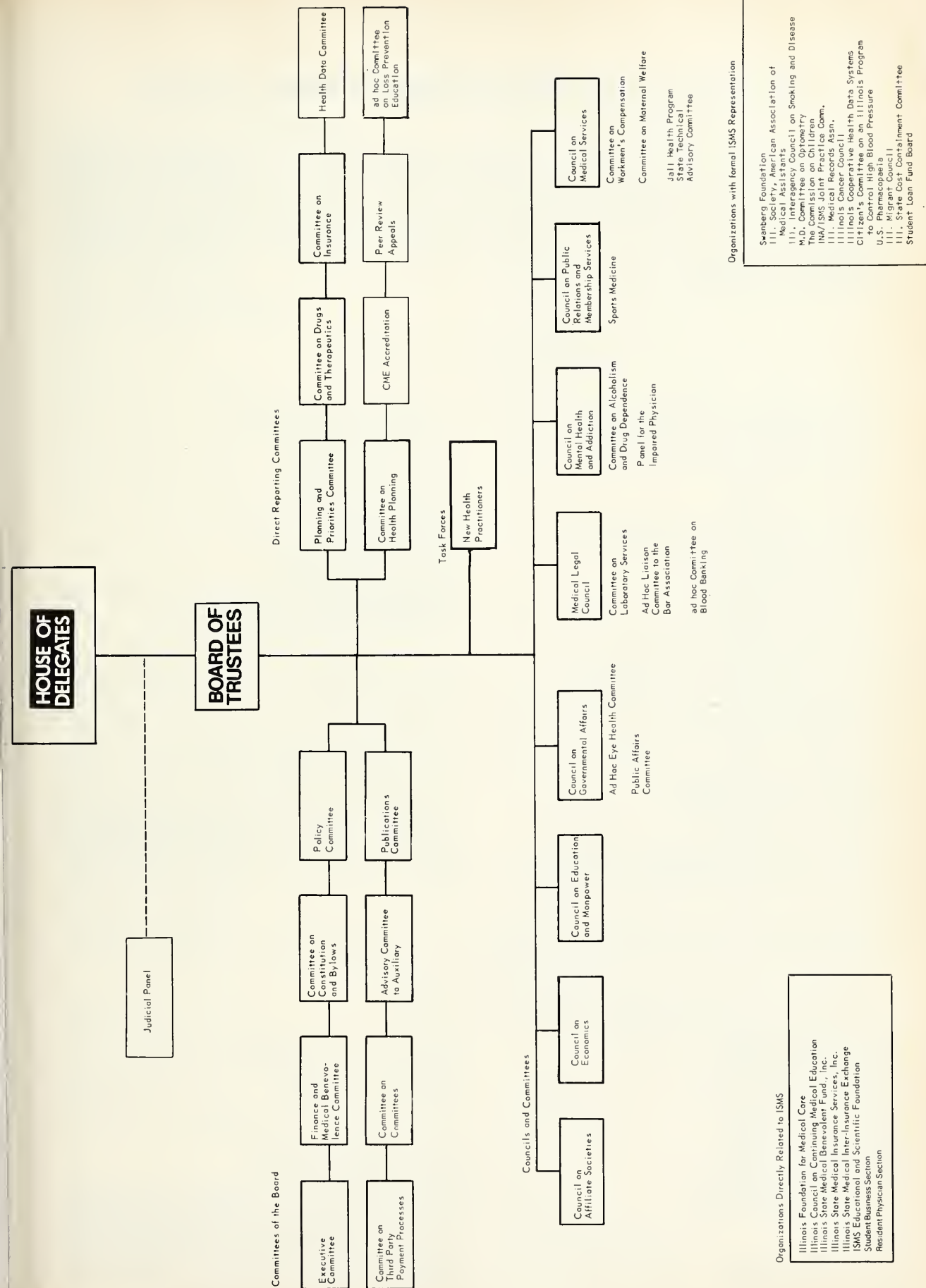
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ETHICAL RELATIONS COMMITTEE	TERM EXPIRES
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Frank Luedke, DeKalb .....	1981
Frank Descourouez, Freeport .....	1982

#### PEER REVIEW COMMITTEE

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Frank Luedke, DeKalb .....	1981
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Frank Descourouez, Freeport .....	1982





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STAFF: Division for Specialty Societies

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The Council on Economics maintains ongoing dialogue with third party payors and considers issues regarding the costs and utilization of health care services. The council is interested in effective practice management and the economic impact of both government health policies and new health care delivery systems.



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STAFF: Division of Education, Manpower and  
Convention Services

### Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

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John R. Lumpkin, Chicago  
Paul Mahon, Springfield  
Tassos Nassos, Northbrook  
Howard Simon, Glencoe  
Alex Spadoni, Joliet  
G. Samuel Stohl, Rockford

### CONSULTANTS:

George Burke, Rock Island  
Robert R. Hartman, Jacksonville  
P. John Seward, Rockford

### ILLINOIS MEDICAL GROUP MANAGEMENT

ASSN. REP.  
Norma de la Cerna, Chicago

AUXILIARY REPRESENTATIVE  
Mrs. Alan Taylor, Danville

RESIDENT PHYSICIANS REPRESENTATIVE  
Linda Hughey Holt, Chicago

STUDENT REPRESENTATIVE  
Wayne Wheeler, Champaign

STAFF: Governmental Affairs Division

### Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

### Committees:

Ad Hoc Eye Health  
Public Affairs

## AD HOC EYE HEALTH COMMITTEE

Carl Garfinkle, Arlington Heights, *Chairman*  
Charles Mullenix, Glenview  
Burton Russman, Chicago

Frank Snell, Decatur  
Robert W. Webb, East Alton

## PUBLIC AFFAIRS COMMITTEE

Don E. Hinderliter, Rochelle, *Chairman*  
James H. Andersen, Oak Brook  
Eugene Branovacki, Chicago  
Robert Chapman, Normal  
Louis Dondanville, Moline  
Mack W. Hollowell, Charleston  
Sandra J. Olson, Chicago  
Edward Ragsdale, Alton  
Willard C. Scrivner, Belleville  
Herbert Sohn, Chicago  
A. E. Steer, Springfield  
Ronald E. Sumner, Peoria  
Mrs. Alan Taylor, Danville

George Wilkins, Edwardsville

### CONSULTANT

Joseph Perez, Rockford

STAFF: Governmental Affairs Division

### Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

## MEDICAL LEGAL COUNCIL

Donald Aaronson, Chicago, *Chairman*  
Nelson Borelli, Wilmette  
Leonard Klawns, Joliet  
Guy Matthew, Glen Ellyn  
Morgan Meyer, Lombard  
Lawrence K. Richards, Urbana  
Marshall Segal, Chicago  
Leonard Silverman, Flossmoor  
Sam Sugar, Evanston  
Robert Sumner, Harrisburg  
J. Robert Thompson, Oak Park (*Lab. Services*)  
Michael Victor, Buffalo Grove

### CONSULTANTS:

Fred Z. White, Chillicothe  
Kenneth Hurst, Naperville

### RESIDENT REPRESENTATIVE

John Hall, Carbondale

### STUDENT REPRESENTATIVE

James Kelly, Chicago

STAFF: Division of Publications, Medical-Legal and Mental Health

### Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations for methods of elevating and maintaining the standards of medical laboratories in Illinois. In addition, the council shall be concerned with standards of practice, licensure and quackery.

### Committees:

Impartial Medical Testimony

Laboratory Services

Ad Hoc Statewide Bloodbanking Coordinating Committee

## COMMITTEE ON LABORATORY SERVICES

J. Robert Thompson, Oak Park, *Chairman*  
Newell Braatelein, Moline  
Robert Carrara, Geneva  
Hershal Fulcher, Springfield  
John Mason, Hines  
Richard Sassetti, Chicago  
Marshall Short, Chicago  
Albert Sion, Riverside  
Peter Soto, Belleville  
Earl Suckow, Mt. Prospect  
Benjamin Williams, Urbana

### CONSULTANTS:

Alfred J. Kiessel, Decatur

Joseph Sherrick, Chicago

STAFF: Division of Publications, Medical-Legal and Mental Health

### Responsibilities and Purposes:

The Committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.



## COUNCIL ON MENTAL HEALTH AND ADDICTION

Arthur R. Traugott, Urbana, *Chairman*  
Jerome Beigler, Chicago (*IPS Liaison*)

Douglas R. Bey, Normal  
George Borge, LaGrange  
Leroy Levitt, Chicago  
Edward Senay, Chicago  
(*Comm. on Alcoholism & Drug Dependence*)

Mark Sinibaldi, Joliet  
Garth Smith, Hinsdale  
Robert Study, Chicago  
Kishore Thampy, Chicago  
James West, Evergreen Park  
Arthur Woloshin, Highland Park

### CONSULTANT:

Joseph Perez, Rockford

### AUXILIARY REPRESENTATIVE

Mrs. Jack Brodsky, Champaign

### STUDENT REPRESENTATIVE

Frank J. Pieri, Berwyn

### RESIDENT REPRESENTATIVE

Raymond Maciejewski, Springfield

STAFF: Division of Publications, Medical-Legal and Mental Health

### Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information, and recommend appropriate action. It shall also be concerned with reviewing legislation and regulations related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

### Committee:

Alcoholism and Drug Dependence

## COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Edward C. Senay, Chicago, *Chairman*

Richard Banta, Rockford  
Lee Gladstone, Chicago  
Richard Lee, Peoria  
Kermit Mehlinger, Chicago  
Donald Sellers, Des Plaines

### CONSULTANTS:

Linda Hargnett, DDC, Chicago  
Msgr. Ignatius McDermott, Chicago Catholic Charities  
J. Roalda Alderman, Div. of Alcoholism, Chicago  
Mrs. Harold Keegan, ISMS Auxiliary, Kankakee

STAFF: Division of Publications, Medical-Legal and Mental Health

### Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the mis-

use of alcohol and drugs. The committee's functions include: (1) study, research and disseminate educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products; and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

In April, 1977, ISMS established the Panel for the Impaired Physician. The Panel, which reports to the Committee on Alcoholism and Drug Dependence, consists of physicians who treat fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to physical disabilities, mental or emotional disturbances.

## COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Peter Vinciguerra, Libertyville, *Chairman*

Albino Bismonte, Gurnee  
Mark Bullock, Peoria  
Jack L. Gibbs, Canton  
Adarsh Kumar, Springfield  
Milton Kurth, Chicago  
H. Bates Noble, Chicago  
Reuben Ramkissoon, Hinsdale  
Leo Wrona, Joliet

### CONSULTANT:

Joseph Perez, Rockford

### RESIDENT REPRESENTATIVE

Brad Epstein, Chicago

### AUXILIARY REPRESENTATIVE

Mrs. Don Hinderliter, Rochelle

STAFF: Division of Public Relations and Membership Services

### Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

### Committees:

Sports Medicine

## SPORTS MEDICINE COMMITTEE

H. Bates Noble, Chicago, *Chairman*  
Bernie Cahill, Peoria  
Henry Dold, Arlington Heights  
Clarence Fossier, Lake Forest  
Joseph Hinkamp, Glenview  
J. M. Ingalls, Paris  
Jacob Suker, Chicago  
Basilius Zaricznyj, Springfield  
CONSULTANTS:  
Audley Connor, Jr., Chicago  
Robert C. Hamilton, Chicago

STAFF: Division of Public Relations and Membership Services

### Responsibilities and Purposes:

To conduct programs aimed at improving the recognition and treatment of athletics-related injury and disease; provide educational material to junior and senior high school coaches and trainers; and work with other groups and organizations involved in sports medicine activities.

## COUNCIL ON MEDICAL SERVICES

Joseph D. Winterhalter, Jacksonville, *Chairman*  
Wallace P. Berkowitz, Belleville  
Joan Cummings, Hines  
Theodore Dastych, Joliet  
C. Larkin Flanagan, Chicago  
A. Everett Joslyn, River Forest  
William M. Lees, Lincolnwood  
David B. Littman, Highland Park  
John T. McEnery, Oak Park  
Daniel J. Pachman, Chicago  
Roger N. Pesch, Wheaton  
Eugene J. Rogers, Chicago  
Robert C. Stepto, Chicago

### CONSULTANTS:

Vincent A. Costanzo, Jr., Chicago  
John J. Ring, Mundelein

AUXILIARY REPRESENTATIVE  
Mrs. Irvin Blumfield, Alton

STUDENT REPRESENTATIVE  
Linda Tetzlaff, Chicago

STAFF: Division of Medical Services

### Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workmen's compensation, and the penal health care services.

### Committees:

Maternal Welfare  
Committee on Workmen's Compensation  
Illinois Jail Health Program—State Technical Advisory Committee

## COMMITTEE ON MATERNAL WELFARE

### DISTRICT MEMBERS AND ALTERNATES (alternates in italics)

Robert C. Stepto, *Chairman*  
1. Hugh C. Falls, Lake Forest  
*Theodore London*, Aurora  
2. Carl P. Mattioda, Streator  
*Ruthachai Rithaporn*, Princeton  
3. Robert C. Stepto, Chicago  
*Warren H. Staley*, Chicago  
4. Raoul E. Reinertsen, Canton  
*Charles C. Egley*, Peoria  
5. William H. Schultz, Springfield  
*Kofi S. Amankwah*, Springfield  
6. Richmond H. Simmons, Jacksonville  
*Richard D. Yoder*, Alton  
7. Herbert W. Thompson, Decatur  
*William L. Wagner*, Decatur  
8. Lewis Trupin, Champaign  
*Larry R. Lane*, Champaign  
9. Urduja Pulido, Murphysboro  
*Roger N. Klam*, Carbondale

10. Stephen V. Mueller, Belleville  
*Casimiro Garcia, Jr.*, Belleville  
11. Salvatore Reda, Wheaton  
*Kenneth M. Uznanski*, Joliet  
12. John F. Hubbard, Sterling  
*Gordon T. Burns*, Rockford

### CONSULTANTS:

Robert R. Hartman, Jacksonville  
John Lewis, Lake Forest  
Augusta Webster, Chicago

STAFF: Division of Medical Services

### Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.



## COMMITTEE ON WORKMEN'S COMPENSATION

Eugene J. Rogers, Chicago, *Chairman*  
Milton R. Carlson, Champaign  
Harry C. Coblens, Chicago  
Donald J. Crane, Peoria  
Joseph Schiff, Chicago  
Michael R. Treister, Chicago  
Peter Wolkonsky, Chicago

STAFF: Division of Medical Services

### Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the Workmen's Compensation system in Illinois.

## STATE TECHNICAL ADVISORY COMMITTEE ILLINOIS JAIL HEALTH PROGRAM, 1980-1981

Robert J. Kramer, Joliet, *Chairman*  
Margaret Connolly, Assoc. Dir., Ambulatory Care,  
UI Hosps. & Clinics  
Hon. Thomas P. Durkin, Ill. State Bar Association  
Cyril L. Friend, Jr., DDS, Ill. State Dental Society  
Marie Hall, Ill. Department of Corrections  
Sheriff George Kramer, Ill. Sheriffs' Association  
David B. Littman, Highland Park  
Mary Lou Pflum, Div. of Ambulatory Care, IDPH

Joseph D. Winterhalter, Jacksonville  
Margaret Wright, R.S.M., Illinois Pharmacists  
Association

STAFF: Division of Medical Services

### Responsibilities and Purposes:

The STAC provides overall direction to the Illinois Jail Health Program and assists jails in adapting their health systems to meet national standards for medical care. The jail program is funded through a subcontract with the AMA.

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# Committees of the Board of Trustees

## ADVISORY COMMITTEE TO ISMS AUXILIARY

P. John Seward, Rockford, *Chairman*  
Herschel Browns, Chicago  
Morris T. Friedell, Chicago

STAFF: Division of Administration

### Responsibilities and Purposes:

The committee shall consist of the immediate past

president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

## COMMITTEE ON COMMITTEES

Clifton L. Reeder, Wilmette, *Chairman*  
Julian Buser, Belleville  
Lawrence L. Hirsch, Chicago  
George T. Mitchell, Marshall  
Warren D. Tuttle, Harrisburg  
STAFF: Division of Education, Manpower and  
Convention Services

### Responsibilities and Purposes:

The Committee on Committees shall consist of three

members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

## COMMITTEE ON CONSTITUTION AND BYLAWS

Lawrence L. Hirsch, Chicago, *Chairman*  
Robert C. Hamilton, Chicago  
Robert P. Johnson, Springfield  
James Laidlaw, Champaign  
Clifton L. Reeder, Wilmette

**STAFF:** Division of Education, Manpower and  
Convention Services

### **Responsibilities and Purposes:**

The Committee on Constitution & Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

## EXECUTIVE COMMITTEE

Morris Friedell, Chicago, *Chairman*  
Herschel Browns, Chicago  
Jere Freidheim, Chicago  
Robert Hartman, Jacksonville  
Lawrence Hirsch, Chicago  
Eugene Johnson, Casey  
P. John Seward, Rockford  
Fred Z. White, Chillicothe

**BY INVITATION** (without vote)  
Robert P. Johnson, Springfield

**STAFF:** Division of Administration

### **Responsibilities and Purposes:**

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the

Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

## FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Jere E. Freidheim, Chicago, *Chairman*  
Audley F. Connor, Jr., Chicago  
Eugene P. Johnson, Casey  
Joseph Perez, Rockford

### **AUXILIARY REPRESENTATIVES**

Mrs. A. Martinucci

**STAFF:** Division of Administration

### **Responsibilities and Purposes:**

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the

Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.

2. Keep the names of the beneficiaries confidential and known only to the committee.

3. Determine the allotment for each recipient.

4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

## POLICY COMMITTEE

Alfred Kiessel, Decatur, *Chairman*

George Burke, Rock Island

Richard Rovner, Chicago

**STAFF:** Division of Education, Manpower and  
Convention Services

### **Responsibilities and Purposes:**

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.



## PUBLICATIONS COMMITTEE

Joseph Sherrick, Chicago, *Chairman*  
Henrietta Herbolzheimer, Chicago  
Kenneth Hurst, Naperville  
Robert Prentice, Springfield  
John J. Ring, Mundelein

STAFF: Division of Publications, Medical-Legal and  
Mental Health

### Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to accept-

ance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

### IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*  
Eli L. Borkon, Carbondale  
Eugene J. Rogers, Chicago  
Raymond A. Dieter, Jr., Glen Ellyn  
James G. Ekeberg, Palatine  
Ediz Z. Ezdinli, Kenilworth  
Carl Neuhoff, Peoria  
Constantine S. Soter, Northbrook  
Donald D. VanFossan, Springfield

## THIRD PARTY PAYMENT PROCESSES COMMITTEE

Fred Z. White, Chillicothe, *Chairman*  
Alfred Clementi, Arlington Heights  
Allan L. Goslin, Streator  
Robert R. Hartman, Jacksonville  
Harold J. Lasky, Chicago  
Cyril C. Wiggishoff, Chicago

ILL. MEDICAL GROUP MNGMT. ASSOC. REP.  
Mr. Sherwin Sern, McHenry

STAFF: Division of Field Services

### Responsibilities and Purposes:

The Third Party Payment Processes Committee is responsible for matters concerning the Illinois Department of Public Aid. The Committee deals with Medicaid reimbursement, administration, and auditing practices. The Committee also oversees the Medicaid Membership Services program.

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# Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

## COMMITTEE ON CME ACCREDITATION

Dean R. Bordeaux, Peoria, *Chairman*  
Philip D. Anderson, Chicago  
Robert A. Behmer, Rockford  
James H. Geist, Kankakee  
Joseph D. McKay, Elmhurst  
Julius S. Newman, Aurora  
Maynard I. Shapiro, Chicago  
Dennis J. Stanczyk, Belleville

### CONSULTANTS:

Audley F. Connor, Chicago  
Lawrence L. Hirsch, Chicago

Warren D. Tuttle, Harrisburg

STAFF: Illinois Council on Continuing Medical Education

### Responsibilities and Purposes:

Adopt necessary procedural rules and prescribe forms to be used in the conduct of CME accreditation, within prescribed policies. Review Sponsor applications and Survey Team reports for intrastate CME Sponsors, and make decision on grant of initial accreditation and continuation of accredited status.

## COMMITTEE ON DRUGS AND THERAPEUTICS

Charles A. Beck, Chicago, *Chairman*  
Vincent A. Costanzo, Jr., Chicago  
Amin N. Daghestani, Skokie  
William Hanigan, Peoria  
John Hyde, Oak Park  
Dorothy Hubler, Casey

### CONSULTANTS:

Louis Gdalmann, R.Ph., Oak Brook  
Kerrison Juniper, Jr., Springfield

STAFF: Division of Education, Manpower and  
Convention Services

### Responsibilities and Purposes:

The committee shall meet periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Special approval of drugs not listed in the Manual also falls under the purview of the committee and is reported to IDPA. Comments or suggestions made by the membership regarding drugs are reviewed by the committee.

## HEALTH DATA COMMITTEE

Allan Goslin, Streator, *Chairman*  
Andrew Brislen, Chicago  
Audley F. Connor, Chicago  
Alexander Goldstein, Harrisburg  
Donald H. Hanscom, Hinsdale  
Henrietta Herbolsheimer, Chicago  
James Laidlaw, Champaign  
Joseph R. O'Donnell, Glen Ellyn  
Paul Peterson, Chicago  
Clifton L. Reeder, Wilmette  
Walter Stevenson, Quincy  
Ben T. Williams, Urbana

### CONSULTANT:

Roger N. White, Executive Administrator

STAFF: Division of Field Services

### Responsibilities and Purposes:

The committee shall maintain ongoing awareness of:  
(1) systems for the collection and dissemination of

health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of PSROs, HSAs, the Illinois Cooperative Health Data System (ICHDS), governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the Committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees and other appropriate persons within ISMS advised on data collection matters.

## COMMITTEE ON HEALTH PLANNING

Samuel L. Andelman, Skokie, *Chairman*  
Ronald F. Albrecht, Chicago  
Eli L. Borkon, Carbondale  
Angelo Creticos, Chicago  
Gerald W. Grawey, Peoria  
M. Kenneth Kaufmann, Greenville  
John S. Schweppe, Chicago  
Robert C. Wanless, Belleville  
Richard S. Webb, Rockford

### CONSULTANTS:

Henrietta Herbolsheimer, Chicago  
Joseph R. O'Donnell, Glen Ellyn

Alfred J. Kiessel, Decatur

STAFF: Division of Field Services

### Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.

## COMMITTEE ON INSURANCE

Gerald S. Modjeska, Chicago, *Chairman*  
Anne L. Barlow, N. Chicago  
Philip Boren, Carmi  
Herbert H. Epstein, Glencoe  
John P. Henderson, Peoria  
Alan B. Spacone, Oak Brook

### CONSULTANTS:

George T. Mitchell, Marshall  
Clifton Reeder, Wilmette

STAFF: Division of Medical Services

### Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the programs' administrators.



## AD HOC COMMITTEE ON LOSS PREVENTION EDUCATION

Philip Boren, Carmi  
Alfred Clementi, Arlington Heights  
Robert R. Hartman, Jacksonville  
Warren Tuttle, Harrisburg  
Richard Wilbur, Lake Forest

### Responsibilities and Purposes:

The ad hoc Committee on Loss Prevention Education

seeks to help physicians identify legal dicta and court procedures and the application of these to medical practice. It seeks to enable physician identification of potential problems in various medical procedures and practice settings and effect a change in same. Educational efforts are intended to improve the quality of medical care and prevent law suits.

## PEER REVIEW APPEALS COMMITTEE

George J. Gertz, Chicago, *Chairman*  
Boonmee Chunprapaph, Hinsdale  
Vincent C. Freda, Chicago  
Eugene T. Hoban, Oak Park  
Carl Johnson, Moline  
Lloyd E. Thompson, East St. Louis  
James H. Topp, Rockford

STAFF: Division of Medical Services

### Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee is the State Society's liaison to local peer review committees and monitors review activities around the state.

## PLANNING AND PRIORITIES COMMITTEE

Fred Z. White, Chillicothe, *Chairman*  
Lorris M. Bowers, Peoria  
Alfred J. Clementi, Arlington Heights  
Jere E. Freidheim, Chicago  
Robert C. Hamilton, Chicago  
Henrietta Herbolzheimer, Chicago  
Eugene P. Johnson, Casey  
Robert P. Johnson, Springfield  
Albert W. Ray, Jr., Joliet  
John J. Ring, Mundelein  
Cyril C. Wiggishoff, Chicago

STAFF: Division of Administration

### Responsibilities and Purposes:

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

## TASK FORCE ON NEW HEALTH PRACTITIONERS

Pedro A. Poma, Melrose Park, *Chairman*  
Howard Burkhead, Evanston  
Joan Cummings, Hines  
Melvin Freedman, Granite City  
John Froiland, Chicago  
Allan Goslin, Streator  
Henri Havdala, Chicago  
Boyd McCracken, Greenville  
Daniel Pachman, Chicago  
Richard Rovner, Chicago  
Harry Springer, Winnetka  
Harold Zenisek, Rockford

STAFF: Division of Publications, Medical-Legal and Mental Health

### Responsibilities and Purposes:

The Task Force on New Health Practitioners shall be responsible for reviewing the activities of health professionals sometimes known as "physician extenders," whose activities tend to duplicate or encroach upon the prerogatives and responsibilities of physicians licensed to practice medicine in all its branches. The task force shall make its recommendations to the Board of Trustees regarding allied health personnel, their role and function within the medical model.

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# Direct Reporting Committees of the House of Delegates

## JUDICIAL PANEL COMMITTEE

Frank B. Norbury, Jacksonville, *Chairman*  
Donald Aaronson, Niles  
Howard C. Burkhead, Evanston  
Eugene P. Johnson, Casey  
Eugene T. Leonard, Rockford

### Responsibilities and Purposes:

The Panel, whose members are nominated by the

President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical practice. The panel accepts appeals after the case has been heard at the local level.

STAFF: Division of Medical Services

## Other Appointments and Representatives

### REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*  
Albert G. Bledig, Eldorado  
Thomas Schrepfer, Havana

STAFF: Division of Education, Manpower and  
Convention Services

#### Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

### REPRESENTATIVES TO INA-ISMS JOINT PRACTICE COMMITTEE

James E. Coeur, Carthage  
Loren Boon, Danvers  
Audley F. Connor, Jr., Chicago  
Allan Goslin, Streator

STAFF: Division of Education, Manpower and  
Convention Services

#### Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and

nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

### REPRESENTATIVES TO ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Audley F. Connor, Chicago  
Alexander Goldstein, Harrisburg  
Allan L. Goslin, Streator  
Donald H. Hanscom, Hinsdale  
Henrietta Herbolzheimer, Chicago  
Don Kline, Peoria

Joseph R. O'Donnell, Glen Ellyn  
Clifton L. Reeder, Wilmette  
Walter Stevenson, Quincy  
Roger N. White, *Executive Administrator*, ISMS  
Ben T. Williams, Urbana

### REPRESENTATIVES TO ILLINOIS STATE COST CONTAINMENT COMMITTEE

Robert T. Fox, Glenview, *Vice-Chairman*  
David S. Fox, Chicago  
Robert R. Hartman, Jacksonville  
J. M. Ingalls, Paris  
Clifton Reeder, Wilmette  
P. John Seward, Rockford

#### Responsibilities and Purposes:

This committee—co-sponsored by ISMS, Illinois Hospital Association and the Federation of American Hospitals—was created to implement the National Voluntary Effort program in Illinois. Its goals are to: (A) Bring the rate of increase in hospital costs in line with the growth in the Gross National Product; and (B) Reduce capital expenditures for new hospital plants and equipment.

### ISMS REPRESENTATIVES TO OTHER GROUPS

SWANBERG FOUNDATION, QUINCY  
Robert R. Hartman, Jacksonville

LIAISON TO ILL. SOC. OF THE AMER. ASSOC.  
OF MED. ASSTS.

Robert R. Hartman, Jacksonville

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE  
Charles L. Swarts, Oak Park

ILLINOIS MEDICAL RECORDS ASSOC.  
Clifton Reeder, Wilmette

ILLINOIS MIGRANT COUNCIL  
Raphael Campinini, Chicago

MD COMMITTEE ON OPTOMETRY  
Joel Kaplan, Chicago

STATEWIDE COOPERATING ORGANIZATIONS OF THE  
COMMISSION ON CHILDREN  
Daniel Pachman, Chicago

ILLINOIS CANCER COUNCIL  
William M. Lees, Lincolnwood

CITIZENS COMMITTEE FOR AN ILLINOIS PROGRAM TO  
CONTROL HIGH BLOOD PRESSURE  
R. Ann Irish, Wheaton

U.S. PHARMACOPAEDIA  
Joseph Skom, Chicago  
Vincent Costanzo, Chicago, *Alternate*



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# ISMS SERVICES

## Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 55 East Monroe St., Suite 3510, Chicago, and an office in Springfield at 701 S. Second St. Services of the Society, under the general supervision

of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications, Medical Legal and Mental Health; Education, Manpower, and Convention Services; Medical Services, Field Services, Computer Services and Services for Specialty Societies.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

Specific areas of responsibility and staff assignments will be identified to any member upon request.

## DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The headquarters office has been organized by di-

visions to provide the membership of the Society with the best professional staff services available.

The Assistant Executive Administrator serves within this Division as a coordinator for programs of the state society. Further coordination between programs of the State Society and the County Medical Societies is achieved through Field Services Representatives.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

The Division also supplies accounting, computer and legal services to Insurance Services, the Insurance Exchange and the Illinois Council on Continuing Medical Education, on a cost allocated basis.

## DIVISION OF COMPUTER SERVICES

This Division was established in 1976 as a result of the Board of Trustees authorization to purchase a computer for the purpose of cataloging claim statistics in conjunction with the Hartford Liability Insurance program, sponsored by ISMS. Computer requirements were soon increased when the doctor-owned Insurance Exchange was established that same year. Insurance Services currently uses ISMS hardware and operations for its broad variety of business programs.

Computer services are provided internally to ISMS for

its centralized membership dues billing and collection system, financial record keeping and label production for the many Society mailings. A physician data base is currently being assembled as an information source for our councils and committees.

The Computer Service Division is being organized to provide limited time sharing arrangements and services to outside organizations. As we complete internal projects we shall seek further users in our effort to continue a cost effective system.



## DIVISION OF EDUCATION, MANPOWER AND CONVENTION SERVICES

The Division of Education and Manpower was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in concert with the AMA in keeping abreast of changes in medical school curricula, and in postgraduate medical

education.

It is also responsible for coordinating meetings and conventions for all divisions, as well as the services and arrangements incident to the annual and interim sessions of the House of Delegates and provides staff services for the Resident Physicians Section, Student Business Section, and the American Association of Medical Assistants, Illinois Society.

## DIVISION OF FIELD SERVICES

The primary responsibility of Field Services is to provide liaison, service and education to the Society's membership through Field Service Representatives. Each Field Representative has the responsibility for liaison with component societies, allied professions and government agencies, to insure State Society representation and to provide a means for communication; service to the trustees, officers, executives, general membership and county medical societies; to provide a constant update on ISMS information, programs and resources; and education to the general membership through the distribution of a wide variety of issues affecting the practice of medicine.

Specific areas of activity include health planning, President's Tour, Trustee District meetings, the legislative Key-Man program, public affairs activity, Medicaid and Medicare membership services, audit assistance, and

CHAMPUS professional relations.

Additional division activities include staffing the Third Party Payment Processes Committee, which deals with Medicaid matters and the Health Planning Committee, which closely follows the activities of the State Planning Agency, Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies. The Division is also responsible for all activities related to campaigns of ISMS candidates for AMA office.

Staff of the Division attend meetings of governmental and professional organizations involved in the above described areas and participate in hearings and programs used to develop policy and programs regarding these issues.

## GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically-related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

### Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

### Activities

The division also staffs the Public Affairs Committee and the Ad Hoc Eye Health Committee.

## DIVISION OF MEDICAL SERVICES

To respond to the social and economic issues facing physicians, the Division of Medical Services conducts ongoing liaison activities with various public, governmental, professional, and private organizations. Through the Council on Economics and the Council on Medical Services, the Division reviews current subjects affecting the physician's practice environment, including his involvement with patients, medical facilities, public health programs, and health insurance carriers. The products of council meetings may take the form of educational seminars, informational materials, legislation, or position statements. In addition, Division staff monitors the development of new medical delivery systems to keep the Councils informed of potential changes affecting the practice milieu.

The Division is also responsible for staffing the ISMS Committee on Insurance, which monitors ISMS-sponsored insurance programs for the membership; the Judicial Panel, which conducts disciplinary procedures in accordance with Chapter XI of the ISMS Constitution and Bylaws; and the Peer Review Appeals Committee, which hears appeals of local peer review cases.

The Division has also been charged with implementation of the Illinois Jail Health Program, a project designed to improve the health care delivery systems of county jails. Staff responsibilities include providing technical assistance to jail sites and support to the program's State Technical Advisory Committee.

### Council on Medical Services

The council studies issues and implements programs concerning the physician's role in health care facilities, the effective and appropriate delivery of medical services and the health care needs of specific population groups, such as children, the elderly, and the poor. Council activities also include maintaining liaison with the Illinois Department of Public Health and various health care organizations relating to areas such as hospital-medical staff relations, emergency medical services, nursing care, nutrition, school health, maternal welfare, and workmen's compensation.

### Council on Economics

The principal duty of the Council on Economics is to

keep abreast of problems arising out of physicians' relationship with third-party payors. Additional areas of Council activity are the monitoring of government economic policies in the health care arena and assisting physicians with practice management problems. Serving as consultants to the Council are representatives from the Health Insurance Association of America and the Illinois Blue Cross/Blue Shield Association.

### Committee on Insurance

ISMS offers seven insurance plans as benefits to the membership. Life, Hospital Benefit, Major Medical, Excess Major Medical, Disability, Business Overhead and Worker's Compensation programs are underwritten and administered through outside organizations. These are monitored and periodically modified by the Committee to reflect the changing needs of the membership.

### Judicial Panel

Panel members are elected by the ISMS House of Delegates and charged with implementing Chapter XI, the disciplinary section of the ISMS Constitution and Bylaws. Meetings are held when ethical relations cases are appealed to the State Society following a hearing at the local or district level.

### Peer Review Appeals Committee

This committee is responsible for hearing peer review cases on the appellate level, in accordance with Chapter XII of the Constitution and Bylaws. Cases concerning appropriate health care services and patient relations are heard by the Committee after they are considered by the local or district peer review committee.

### State Technical Advisory Committee

This steering committee of the Illinois Jail Health Program includes members from the medical, nursing, legal, and correctional fields, with a particular interest in penal medicine. The committee reviews the status of health care delivery in county jails and recommends program objectives.

## DIVISION OF PUBLICATIONS, MEDICAL-LEGAL, AND MENTAL HEALTH

The Division of Publications, Medical-Legal and Mental Health is charged with staff responsibility for activities associated with the Council on Mental Health and Addiction, Medical Legal Council, Task Force on New Health Practitioners, Committee on Loss Prevention Education, Blood Banking and the Publications Committee. Under the councils are several committees and subcommittees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society. Staff functions include various activities in professional liability, as well as work on specific problem areas allied to medical-legal concerns and licensure.

### Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. Printing and duplicating services are fur-

nished either through an in-plant shop or outside services. In addition, mail room services are provided by this division. A small wing mailer, folder and stuffer, and plate burning cabinet are utilized.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS and ISMIS divisions to carry forth their mission, are produced.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.



## DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Division of Public Relations functions both as an outlet to the news media and as a source of information for the membership.

Staff members prepare speeches, slide presentations, pamphlets and other materials on a wide range of topics to support activities of officers, councils and committees. In addition, the Division arranges press conferences and prepares news releases to publicize ISMS actions and views on major issues. Also, the Division serves as liaison to the news media, responding to almost daily requests for background information or summaries of society activities.

Beyond these traditional public relations duties, the Division conducts a number of special, highly successful projects. Among them are:

*President's Tour* . . . takes the ISMS President to each Trustee District and provides an opportunity for mem-

bers to discuss with the president matters affecting medicine and the society. An integral part of the "tour" is press conferences and media interviews as well as civic club speaking engagements arranged by the Division.

*Action Report* . . . is a periodic newsletter which reports on ISMS activities and major events affecting medicine.

*AID (Athletics . . . Injury and Disease)* . . . assists coaches and trainers in prevention, recognition and initial treatment of injuries and illnesses. This sports-medicine newsletter—published three times each year—is distributed to approximately 2,000 junior and senior high school coaches and trainers in Illinois.

*Public Service Announcements* . . . providing general health information are distributed to approximately 150 Illinois radio stations and 28 TV stations.

## DIVISION FOR SPECIALTY SOCIETIES

The Division for Specialty Societies was established in March, 1978 to provide closer liaison with medical specialty organizations in Illinois. The Division handles daily operations of several component groups, and provides staff services on a cost basis.

Administrative services provided are divided into the following primary areas: (1) Routine office management, correspondence and inquiries; (2) Meeting arrangements; (3) Membership promotion and record keeping; (4) Dues collection and accounting services; and (5) Newsletters and other membership publications.

An important function of the Division is to maintain liaison between ISMS and specialty society officers. The arrangement also permits close liaison with other ISMS divisions whose activities often affect specialty society interests, such as the Governmental Affairs Division.

The Division also staffs the Council on Affiliate Societies which is comprised of representatives from 22 Illinois specialty societies. The Council is responsible for providing specialty consultation to other ISMS councils and committees.

## SPECIAL PUBLICATIONS

### On the Legislative Scene

Emanating from the Springfield Regional Office is the newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in

Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

### Action Report

"Action Report" is a periodic newsletter designed to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to physicians as quickly as possible so that appropriate responses may be made.

## SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for

individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

In February, 1978, a special adjunct to the Scientific Speakers Bureau was formed through a grant from the

Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism. That grant facilitates presentations by a special roster of speakers in alcoholism education.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Publicity to media in the area of the meeting will

be handled by ISMS upon request of the county society.

3) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

4) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

## PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special ac-

tivities. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

### PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a physician.

More than 600 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will

contact the service.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. The physician is also sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

Another important function of the Physician Recruitment program is the Doctor's Job Fair, in which communities meet face-to-face with physicians seeking practice opportunities.

### ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to \$750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the

student's current financial need. A low interest rate is charged from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organi-



zations of the program can recommend candidates annually to the University of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

(1) Freshman student receiving recommendation—five years of practice.

(2) Freshman student receiving financial assistance for four years—four years of practice.

(3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select a practice location of his own choice, provided it is in a community that has a demonstrated physician shortage. The choice is subject to ap-

proval by the program's board. The purpose of this agreement is to provide physicians for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; applicants must also complete the required American Medical College Admission Service forms. This AMCAS application must be on record with the University of Illinois Medical School by November 1. Illinois residency is required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Manager, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 2901, Bloomington, IL 61701.

## IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is divergence of medical opinion in litigation before the court. An IMT examination provides the court with objective, impartial medical data and opinion.

The Illinois State Medical Society played a significant role in the creation and development of the IMT program.

The panel of impartial medical examiners is comprised of physicians who are grouped into medical specialties. Composition of the panel is reviewed periodically to maintain the highest standards for the courts of Illinois.

In 1976 the functions of IMT were expanded to provide service to the Supreme Court Attorney Registration and Discipline Commission. In 1980, impartial review through another panel system, to assist the Illinois Industrial Commission decide disputed cases, was under development.

## ISMS SPONSORED COMMERCIAL INSURANCE PROGRAMS

ISMS members are eligible for a number of insurance programs approved by the Illinois State Medical Society and administered by a reliable broker appointed by the Society for that purpose.

While each plan is described below, more detailed information and application forms can be obtained from the ISMS-approved broker and administrator, Corroon & Black of Illinois, Inc., 135 S. LaSalle St., Chicago, IL 60603. 312/621-4909.

The Society recommends that you check with ISMS, or its broker, before you purchase any insurance program. ISMS coverage may be broader, and savings may be substantial. Also, since the benefits and coverages are subject to change as ISMS reviews and updates its programs, the Society and Corroon & Black have the latest information.

### Group Term Life Insurance

A new program of Group Term Life Insurance, underwritten by the North American Company for Life and Health Insurance, is being introduced. Under this plan, \$25,000 to \$1 million in level term life insurance, with built-in waiver of premium, will be available to mem-

bers and to spouses and employees of members, under age 65. Also, children of members may be insured for up to \$5,000. Coverage is non-cancellable, guaranteed renewable to age 100. Conversion of the full amount of group insurance to permanent individual policy is guaranteed at any time up to age 65.

A 24-hour Accidental Death & Dismemberment Plan is also being introduced which will be available as part of the Group Term Life Insurance Plan or by itself.

### Group Disability Program

Underwritten by the Commercial Insurance Company, the ISMS Group Disability Program can provide income from \$100 to \$400 per week when injury or illness results in total disability. You may choose benefits beginning after four, thirteen or twenty-six weeks of total disability or from the first day due to accident and eighth day due to sickness. The coverage is renewable to age 70 and offers three benefit period choices—Lifetime Accident and (1) Sickness payable to age 65, (2) Sickness payable for 7 years, (3) Sickness payable for 1 year.

The plan is available to all members of the Society and employees of insured members engaged in the medical profession up to age 56, who are regularly attending all of the usual duties of their occupation.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

### Professional Overhead Expense Plan

Under the ISMS Professional Overhead Expense Plan, underwritten by the Provident Life and Accident Company, coverage of \$200 to \$3,500 per month may be purchased. Beginning with the 31st day of total disability, office overhead expenses will be paid up to the maximum amount of the monthly benefit selected; benefits are payable for up to 24 months regardless of any other insurance carried.

Covered expenses include rent, utilities, employee salaries, monthly pro rata of annual (A) contributions, (B) membership fees and dues, (C) accountant services and (D) depreciation of furniture and equipment, and other fixed expenses customary to the profession. Not covered items include personal income, salaries for other MD's, principal payments on indebtedness, cost of implements and pharmaceutical products, and personal insurance premiums.

Under Revenue Ruling 55-264, premiums for professional overhead insurance are tax deductible for individuals and partnerships; professional corporations should contact their tax advisors.

All members of the Society under age 65 who are actively engaged in their profession on a full-time basis are eligible to apply.

### Group Major Medical Expense Plan

The ISMS Group Major Medical Plan, which is underwritten by the Commercial Insurance Company, is designed to provide comprehensive protection against nearly all of the expenses of medical care.

The plan has a maximum benefit and expenses must be incurred within three years from the date of the first covered expenses. Under the Major Medical Plan, you select a calendar year deductible of \$500 or \$1000, which applies to each insured person (yourself, spouse, and children). This plan will pay up to 80% of a \$150 a day room and board rate and an additional 80% of up to \$150 a day in an intensive care unit.

After satisfying the selected deductible, the plan will pay 80% of the following expenses: hospital supplies and services; doctors medical services; surgeons and assistant surgeons; anesthetists, diagnostic laboratory and x-ray; registered nurses; ambulance services; prescription drugs and medicines; physiotherapy; therapeutic equipment rentals; artificial limbs, oxygen and blood.

This plan is available to all members of the Society and employees of insured members who are under age 65 and regularly attending to all of the duties of their profession.

### Excess Major Medical Plan

The ISMS Excess Major Medical Plan compensates for medical expenses not covered by other medical plans, paying 100% of all eligible medical expenses up to ten years, or a maximum of \$500,000 after the deductible

has been satisfied. The Sentry Insurance Company underwrites this program.

The plan is available with a \$15,000, \$20,000 or \$25,000 deductible. It may be obtained without evidence of insurability. The plan becomes effective when eligible medical expenses incurred within a three year period exceed the deductible.

After satisfying the deductible, the plan will pay 100% of the following expenses: medical care and treatment by a physician; semi-private room and board; private duty nursing services; Convalescent Home confinement, up to \$50 a day and up to 90 days a year; physiotherapy by a licensed physiotherapist; prescription drugs, medicines and antibiotics; dressings, casts, splints, trusses, braces and crutches; rental of a wheelchair, hospital-type bed, iron lung, and other therapeutic equipment; blood and blood plasma; X-ray and radiation therapy; diagnostic tests and examinations; dental services for treating accidental injury to natural teeth; oxygen and anesthesia; ambulance service, up to \$200 in any period of six consecutive months; assistant surgeon, up to 20% of the Eligible Expenses for the chief surgeon; anesthesiologist, up to 15% of the Eligible Expenses for the chief surgeon.

All members of the Society, their spouse, unmarried children under age 25, and their eligible employees who are now working full time in the medical profession, who are under age 65 may enroll. Eligible applicants are guaranteed acceptance regardless of personal health history, subject to a pre-existing conditions limitation.

### Hospital Benefit Plan

Under the Hospital Benefit Plan, which is underwritten by the Hartford Accident and Indemnity Company, the insured is paid \$25, \$50 or \$100 directly, depending on the plan selected, for every day of confinement to the hospital. Benefits begin with the first day of confinement and are payable up to 365 days for each cause of confinement. Benefits are automatically doubled for hospital confinement due to cancer or for confinement in an intensive care unit for those insureds under age 65. Benefits are payable regardless of other insurance the insured may have.

During special enrollment periods, all members, employees, and their families, are able to participate. Eligible applicants are guaranteed acceptance regardless of personal health history subject to a pre-existing conditions limitation.

### Workers' Compensation Insurance

The Dodson Savings Plan has been approved by the Illinois State Medical Society as a proven way to reduce the cost of Workers' Compensation insurance when claim costs are held to a minimum.

Based upon the loss experience of participating physicians, a return on premium is declared at the end of each premium year, with savings checks returned to policyholders. Policies are issued by Casualty Reciprocal Exchange, a member of the Dodson Insurance group. Rates are standard and approved for this class of employment. Savings are best when safety is maintained in all job related activities.

Savings are paid as earned within about 90 days after policy expiration or when payroll audits are completed.

For further details write or call collect to the managers, Dodson Insurance Group, P.O. Box 559, Kansas City, MO 64141. Phone 816-361-3400.



# Ancillary Organizations

## Illinois State Medical Society Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to community health projects, medical legislation, and fund raising for research and education.

Community health projects which will receive special emphasis this year are *Vial of Life*, an emergency program for senior citizens; *Health Careers*, educational opportunities for teenagers; *Immunization*, required protection for infants and children; and *Shape Up For Life*, a nationwide campaign to convince everyone that eating right and exercising regularly are the ways to establish and maintain optimum health.

Legislative activities during 1980-81 will center on the many state and national issues which affect health care and the practice of medicine. The Auxiliary will stress bill awareness, letter writing, personal contact, and political involvement on the part of its members. A "Day in Springfield" will acquaint Auxiliaries with their legislators and pending legislation.

Fund raising for the American Medical Association Education and Research Foundation will continue to be a major undertaking of the Auxiliary. At the AMAA Convention last July, the ISMS Auxiliary received first place awards in every category: the state with the largest contribution to AMA-ERF, the state with the largest total dollar contribution (including physicians' contribution), and the state with the largest contribution per capita in the North Central Region. AMA-ERF funds provide financial assistance to medical students and schools and foster scientific and medical research.

The Auxiliary message will be conveyed this year through County Visits, Leadership Seminars in Princeton and Pere Marquette Park, and a Fall Conference in Decatur. Two publications written for and about physicians' spouses will provide additional communication; these are the AMA Auxiliary's FACETS and the ISMS Auxiliary's PULSE.

The Medical Auxiliary gives members an opportunity to share their special concerns with each other and with members of the Medical Society. It extends the work of the physician into the community, improving the quality of life for everyone through education and service. It's

a recognized fact that *we can do more together.*

Mrs. Harlan J. Failor  
President

### OFFICERS

President ..... Mrs. Harlan Failor, Champaign  
President-Elect ..... Mrs. Harold Keegan, Kankakee  
1st Vice-President  
(Membership) ..... Mrs. Donald Hinderliter, Rochelle  
2nd Vice-President  
(Program) ..... Mrs. Gamil Arida, Joliet  
3rd Vice-President  
(Health Projects) ..... Mrs. Irvin Blumfield, Alton  
Secretary ..... Mrs. Robert Webb, Edwardsville  
Treasurer ..... Mrs. Julian Buser, Belleville

### DIRECTORS

Mrs. R. Samuel Hoover, Lake Forest  
Mrs. James Gwaltney, Quincy  
Mrs. Eugene Leonard, Rockford

### EXECUTIVE SECRETARY

Mrs. Jane Swanson  
104 E. Broadway, Suite 5, Monmouth 61462

### PARLIAMENTARIAN

Mrs. Francis Graff, Freeport

### DISTRICT COUNCILORS

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2. Mrs. Louis Tarsinos, Princeton
3. Mrs. W. J. Olszewski, Evergreen Park
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5. Mrs. Robert Reardon, Bloomington
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8. Mrs. Grover Seitzinger, Danville
9. Mrs. Gerald Fox, Mount Vernon
10. Mrs. Paul Norbet, Belleville
11. Mrs. John Simonaitis, Elmhurst
12. Mrs. John Leonard, Roscoe

## COMMITTEE CHAIRMEN

AMA-ERF Chairman .....Mrs. Selig Hodes, Forreston  
AMA-ERF Vice-Chairman .Mrs. Karl Reddies, Freeport  
AMA-ERF

Vice-Chairman ....Mrs. Robert L. Rockey, Freeport  
Archives .....Mrs. Ashvin K. Patel, Bloomington  
Benevolence .....Mrs. August Martinucci, Joliet  
Bylaws .....Mrs. Robert Hartman, Jacksonville  
Community Health .....Mrs. Fred Nathan, Rockford  
Convention .....Mrs. Jack Hull, Champaign  
Convention

Vice-Chairman ....Mrs. Frank A. Lippi, Champaign  
Editorial .....Mrs. Morris Friedell, Chicago  
Fall Conference .....Mrs. Paul R. Stanley, Decatur  
Family Health .....Mrs. Jack Brodsky, Champaign  
Finance .....Mrs. William Hodges, Kankakee  
Health Education—Health

Careers .....Mrs. Donald DePinto, Rockford  
Health Maintenance .....Mrs. Wayne Kassel, Joliet  
Health Projects .....Mrs. Irvin Blumfield, Alton  
Hospitality .....Mrs. William Simon, Decatur  
Humanitarian Award..Mrs. M. W. Hollowell, Charleston  
International

Health .....Mrs. R. Samuel Hoover, Lake Forest

Legislation .....Mrs. Alan Taylor, Danville  
Long Range Planning ...Mrs. Harold Keegan, Kankakee  
Members-at-Large .....Mrs. Earl Klaren, Libertyville  
Membership .....Mrs. Donald Hinderliter, Rochelle  
Program .....Mrs. Gamil Arida, Joliet  
Public Relations .....Mrs. Alex Spadoni, Hinsdale

### SPECIAL COMMITTEES

Child Abuse .....Mrs. Earl Klaren, Libertyville  
Cult Awareness .....Mrs. George Olander, Lake Forest  
Spouses of Physicians in

Training .....Mrs. Edward Szewczyk, Belleville

### REPRESENTATIVES TO ISMS COUNCILS AND COMMITTEES

Benevolence .....Mrs. August Martinucci, Joliet  
Governmental Affairs .....Mrs. Alan Taylor, Danville  
Medical Services .....Mrs. Irvin Blumfield, Alton  
Mental Health and

Addiction .....Mrs. Jack Brodsky, Champaign  
Public Relations &

Membership .....Mrs. Donald Hinderliter, Rochelle

## American Association of Medical Assistants, Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending Medical Assistant Programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are:

Traveling Course Regional Seminars, Annual Symposium, Personal Development Day and the All Day Workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The Annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates Session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, ad-

ministrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with nearly 750 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (*i.e.* group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.



Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), Northshore (Skokie), West Cook (River Grove), Cook County South (Dolton), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), Jefferson-Hamilton (Mt. Vernon), Kane (Elgin), LaSalle, Macon (Decatur), McLean (Bloomington), McHenry, Morgan-Scott (Jacksonville), Peoria, Randolph (Chester), Rock Island, Sangamon (Springfield), Shawnee (Harrisburg), St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will-Grundy (Joliet) and Winnebago (Rockford). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact Elaine Kaiser, CMA, Pres., 9301 Sandpiper Ct., Orland Park, IL 60462 or Marygrace Sanderson, 501 Heathermead Road, Matteson, IL 60443.

### OFFICERS

President—Elaine Kaiser, CMA-A, Orland Park, IL

President-Elect—Mary Lu Ostrowski, CMA, Bloomington

Immediate Past President—Cissy Egly, CMA, Joliet

1st Vice President—Jean Fouts, L.P.N., Normal

2nd Vice President—Mary Palmer, Peoria

Recording Secretary—Edith Whelan, Oak Lawn

Membership Secretary—Dianne Ruedger, Steger

Treasurer—Patricia Mooney, R.N., Galesburg

Speaker of House—Luella Mitchell, Chicago

Vice Speaker—Pauline Klarich, Peoria

Board of Trustees Chairman—Vivian Kraft, CMA, Bloomington

Parliamentary Advisor—Ruby Jackson, CMA, Chicago

Chaplain—Jean Berschinski, Homewood

Historian—Sheri Everhart, Addison

### Physician Advisors

John L. Wright, M.D., Bloomington, *Chairman*

Thomas R. Harwood, M.D., Chicago

Leslie Schwartz, M.D., Chicago

Robert Hartman, M.D., Jacksonville

J. M. Ingalls, M.D., Paris, *Liaison to ISMS*

Allison Burdick, Sr., M.D., Chicago, *Emeritus Member*

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## The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical

Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

### Board of Directors

P. John Seward, Rockford, *Chairman*

Herschel Browns, Chicago

Morris T. Friedell, Chicago

Eugene P. Johnson, Casey

Fred Z. White, Chillicothe

STAFF: Division of Education, Manpower and Convention Services.

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## Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill these purposes: (a) encourage and assist in the development of continuing medical education programs for Illinois physicians that will enhance patient care; (b) study and encourage development of new educational methods, techniques, systems, etc.; (c)

assist learning sources to identify the educational needs of Illinois physicians; and (d) stimulate, motivate, and encourage physicians at all levels throughout the state to participate in formal continuing educational programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates ap-

proved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972. Financial support of the Council is provided primarily by ISMS members' dues.

ICCME unites the resources of the Illinois State Medical Society and the educational resources of the state's medical schools; and independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

#### Current Major Activities

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The ninth Annual Congress will meet in 1981.
2. On behalf of ISMS, perform staff work for accreditation of intrastate CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME planning and organization.
4. Organize workshops on techniques of CME—including an unusual "Workshop on CME Leader-

ship" for leaders of hospital medical staffs and medical societies.

5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. Included are *Your Personal Learning Plan*, a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. For all items now available, request "The Illinois Handbooks on CME Planning—Catalog/Order Form." All publications are available to ISMS members at a 50% discount. To obtain a copy of the Catalog/Order Form just indicate this on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.
6. Publish a monthly calendar of Illinois CME activities for *IMI*.
7. Plan and conduct research studies that contribute to the improvement of CME methods.

#### Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: nine practicing physicians selected by the ISMS Board of Trustees; and eight academic physicians, one selected by each dean of an Illinois medical school.

#### Board of Directors

William M. Lees, Lincolnwood, *President*  
 Donald F. Pochlyly, Hines, *Vice-President*  
 Kenneth A. Hurst, Naperville, *Secretary*  
 Alfred J. Clementi, Arlington Heights, *Treasurer*  
 Ben B. Blivaiss, Chicago  
 Ernst C. Bone, Jacksonville  
 Dean R. Bordeaux, Peoria  
 Michael Dykes, Chicago  
 Linda Gunzburger, Maywood  
 Marten Kernis, Chicago

Alfred J. Kiessel, Decatur  
 Chase P. Kimball, Chicago  
 Charles E. Osborne, Springfield  
 Harold A. Paul, Chicago  
 Ward E. Perrin, Chicago  
 Fred Z. White, Chillicothe  
 Roger Wujek, Litchfield

EXECUTIVE DIRECTOR: Leonard S. Stein, Ph.D.

#### ILLINOIS CME SPONSORS ACCREDITED FOR CONTINUING MEDICAL EDUCATION AS OF OCTOBER 1, 1980

Alexian Brothers Medical Center—Elk Grove Village  
 Alfred Adler Institute of Chicago, Inc.  
 Augustana Hospital—Chicago  
 Belleville Hospital Association for CME  
 (Memorial Hospital, St. Elizabeth Hospital)  
 Carle Foundation Hospital—Urbana  
 Central Community Hospital—Chicago  
 Central DuPage Hospital—Winfield  
 Chicago College of Osteopathic Medicine  
 Chicago Medical Society  
 Chicago Neurological Society  
 Chicago Pediatric Society  
 Christ Hospital—Oak Lawn  
 Columbus-Cuneo-Cabrini Medical Center—Chicago  
 Community Memorial General Hospital—LaGrange  
 Cook County Hospital—Chicago  
 Copley-Mercy CME Consortium—Aurora  
 DuPage County Medical Society  
 Elgin Mental Health Center

FAB<sup>3</sup>-CME, (Forkosh Memorial, Belmont Community, Bethesda, Bethany Methodist, Thorek Medical Center) Chicago  
 Forest Hospital—Des Plaines  
 Gottlieb Memorial Hospital—Melrose Park  
 Grant Hospital of Chicago  
 Henrotin Hospital—Chicago  
 Highland Park Hospital  
 Hinsdale Sanitarium & Hospital  
 Holy Cross Hospital—Chicago  
 Illinois Central Community Hospital—Chicago  
 Illinois Council on Continuing Medical Education  
 Illinois Heart Association  
 Illinois Hospital Research & Educational Foundation—  
 Illinois Hospital Association  
 Illinois Masonic Medical Center—Chicago  
 Illinois Society of Allergy and Clinical Immunology  
 Illinois Society of Ophthalmology and Otolaryngology  
 Illinois Thoracic Surgical Society



Ingalls Memorial Hospital—Harvey  
 Institute for Psychoanalysis—Chicago  
 Jackson Park Hospital—Chicago  
 Kishwaukee Community Hospital—DeKalb  
 Lake Forest Hospital  
 Little Company of Mary Hospital—Evergreen Park  
 Louis A. Weiss Memorial Hospital—Chicago  
 Loyola University Stritch School of Medicine—Maywood  
 Lutheran Hospital—Moline  
 Lutheran General Hospital—Park Ridge  
 MacNeal Memorial Hospital—Berwyn  
 Martha Washington Hospital—Chicago  
 Mary Thompson Hospital—Chicago  
 Mazel Medical Center-Edgewater Hospital—Chicago  
 Memorial Hospital of DuPage County—Elmhurst  
 Mercy Hospital & Medical Center—Chicago  
 The Methodist Medical Center of Illinois—Peoria  
 Michael Reese Hospital & Medical Center—Chicago  
 Mount Sinai Hospital Medical Center of Chicago  
 Northwestern University Medical School—Chicago  
 North Shore Mental Health Association/  
 Irene Josselyn Clinic—Northfield  
 Northwest Hospital—Chicago  
 Northwest Community Hospital—Arlington Heights  
 Norwegian-American Hospital—Chicago  
 Oak Forest Hospital  
 Oak Park Hospital  
 Provident Hospital—Chicago  
 Ravenswood Hospital Medical Center—Chicago  
 Resurrection Hospital—Chicago  
 Riveredge Hospital—Forest Park  
 Riverside Hospital—Kankakee  
 Rock Island Franciscan Medical Center  
 Rockford Memorial Hospital  
 Roosevelt Memorial Hospital—Chicago

Rush Medical College—Chicago  
 Sarah Bush Lincoln Health Center—Mattoon  
 Sherman Hospital—Elgin  
 Silver Cross Hospital—Joliet  
 Skokie Valley Community Hospital—Skokie  
 South Chicago Community Hospital  
 South Shore Hospital—Chicago  
 Southern Illinois Medical Association—Belleville  
 Southern Illinois University School of Medicine—  
 Springfield  
 St. Anne's Hospital—Chicago  
 St. Anthony Hospital—Chicago  
 St. Anthony Hospital—Rockford  
 St. Elizabeth's Hospital—Chicago  
 St. Elizabeth Hospital—Danville  
 St. Francis Hospital—Blue Island  
 St. Francis Hospital-Medical Center—Peoria  
 St. Joseph Hospital—Chicago  
 St. Joseph Hospital—Elgin  
 St. Mary's Hospital—Kankakee  
 St. Mary's Hospital—Streator  
 St. Mary of Nazareth Hospital—Chicago  
 St. Therese Hospital—Waukegan  
 SwedishAmerican Hospital—Rockford  
 Swedish Covenant Hospital—Chicago  
 Tinley Park Mental Health Center  
 University of Chicago Pritzker School of Medicine  
 University of Health Sciences/The Chicago Medical  
 School  
 University of Illinois College of Medicine  
 Victory Memorial Hospital—Waukegan  
 Westlake Community Hospital—Melrose Park  
 West Suburban Hospital—Oak Park  
 Woodlawn Hospital—Chicago  
 Wood River Township Hospital

## Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a 6-member Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC maintains relationships with the several local foundations for medical care and is available to serve

their needs on a cost reimbursement basis.

### IFMC Board of Directors

Joseph Sherrick, M.D., Chicago, *President*  
 Robert P. Johnson, M.D., Springfield, *Vice-President*  
 James Laidlaw, M.D., Champaign, *Secretary-Treasurer*  
 Audley F. Connor, M.D., Chicago  
 Miller Henderson, M.D., Rockford  
 Lawrence L. Hirsch, M.D., Chicago

## Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General

Assembly and in the U. S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

# Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Exchange was organized to provide comprehensive professional liability insurance for Illinois physicians. Its membership is limited to members of the Illinois State Medical Society.

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement with an initial term of five years, and by each member of the Exchange through his application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of the Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by the Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises three principal functional divisions: Underwriting and Risk Management, Claims, and Administrative Services. Advisory and consultative services are provided by member physicians through a review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Business Manager serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Suite 3440, Chicago, Illinois 60603.

## Board of Directors

Phillip D. Boren  
Alfred Clementi  
Robert Hamilton  
J. M. Ingalls  
Clifton L. Reeder  
Warren D. Tuttle  
Roger N. White

## Officers

Warren D. Tuttle, *Chairman*  
Paul E. Singer, *President*  
Henry Nussbaum, *Vice President*  
Roger N. White, *Secretary-Treasurer*  
Clinton L. Compere, *Medical Director*

## Student Business Section

John Diveris, *Chairman*  
Michael Nieder, *Vice-Chairman/Treasurer*  
Jere Hines, *Secretary*  
Ronald Davis, *Delegate*  
Lori Anderson, *Alternate Delegate*

### School Representatives

Chicago Medical School  
Mark Pappadopoli  
Loyola University  
Ed Kaplan  
Northwestern University  
Jere Hines  
Rush Medical School  
Beth Pletcher

Southern Illinois University  
Tom Nielsen  
University of Chicago  
Moris Senegor  
University of Illinois  
Kurt Elward

The purposes of the Student Business Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Student Business Section shall support the purposes of ISMS as stated in its constitution. The Student Business Section is composed of all student members of ISMS.

## Resident Physicians Section

Larry Gratkins, Chicago, *Chairman*  
William E. Golden, *Vice-Chairman/Treasurer*  
Brad Epstein, *Secretary-Editor*  
David Aizuss, *Delegate*  
David Olive, *Alternate Delegate*

### House Staff Organization Presidents/Representatives

Edgewater Hospital  
J. N. Modi, Chicago  
Hinsdale Sanitarium and Hospital  
Steve Bieliaski, Hinsdale  
Louis A. Weiss Memorial Hospital  
Syam Muntha, Chicago  
MacNeal Memorial Hospital  
Joan S. Wein, Berwyn  
Methodist Medical Center of Illinois  
Michael A. Cottone, Peoria

North Chicago VA Hospital  
Robert A. Williams, North Chicago  
Ravenswood Hospital  
Robert Cotler, Chicago  
Rehabilitation Institute of Chicago  
Robert C. Eilers, Evanston

### Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.



# MEDICAL AND ALLIED HEALTH EDUCATION

## MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

University of the Health Sciences/The Chicago Medical School  
2020 W. Ogden Ave., Chicago, 60612  
Northwestern University Medical School  
303 E. Chicago Ave., Chicago, 60611  
University of Chicago-Pritzker School of Medicine  
950 E. 59th Street, Chicago 60637  
University of Illinois College of Medicine\*  
Chicago Campus—  
1853 W. Polk Street, Chicago, 60612

Loyola University, Stritch School of Medicine  
2160 S. First Ave., Maywood, 60153  
Rush Medical College  
1725 W. Harrison St., Chicago 60612  
Southern Illinois University School of Medicine  
801 N. Rutledge, P.O. 3926, Springfield, 62708  
\*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).

## ALLIED HEALTH EDUCATIONAL PROGRAMS

Accredited by the American Medical Association Committee on  
Allied Health Education and Accreditation

### CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center  
Mount Sinai Hospital Medical Center  
University of Chicago—Lying-in-Hospital

### HISTOLOGIC TECHNICIAN

CHICAGO—Holy Cross Hospital  
Mercy Hospital & Medical Center  
Mount Sinai Hospital & Medical Center  
St. Joseph Hospital  
University of Chicago Hospitals & Clinics  
SPRINGFIELD—Memorial Medical Center  
St. John's Hospital

### MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College  
CARTHAGE—Robert Morris College  
PALATINE—William Rainey Harper College  
RIVER GROVE—Triton College

### MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College  
DIXON—Sauk Valley College  
EAST PEORIA—Illinois Central College  
ELGIN—Sherman Hospital Association  
GODFREY—Lewis & Clark Community College  
MORTON GROVE—Oakton Community College  
OLNEY—Richland Memorial Hospital  
PALOS HILLS—Moraine Valley Community College  
QUINCY—Blessing Hospital  
RIVER GROVE—Triton College

### MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine  
NORMAL—Illinois State University

### MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College  
CHICAGO—Central YMCA Community College  
EAST PEORIA—Illinois Central College  
GRAYSLAKE—College of Lake County  
MORTON GROVE—Oakton Community College  
PALOS HILLS—Moraine Valley Community College

### MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital  
BLUE ISLAND—St. Francis Hospital  
CHAMPAIGN—Burnham City Hospital  
CHICAGO—Augustana Hospital & Health Care Center  
Grant Hospital of Chicago  
Holy Cross Hospital  
Illinois Masonic Medical Center  
Louis A. Weiss Memorial Hospital  
Mercy Hospital & Medical Center  
Michael Reese Hospital & Medical Center  
Rush-Presbyterian-St. Luke's Medical Center  
St. Anne's Hospital  
St. Joseph Hospital  
St. Mary of Nazareth Hospital Center  
University of Illinois College of Medicine  
V. A. Lakeside Hospital

DANVILLE—Lake View Memorial Hospital  
 DECATUR—Decatur Memorial Hospital  
                   St. Mary's Hospital  
 EVANSTON—Evanston Hospital  
 FREEPORT—Freeport Memorial Hospital  
 GENEVA—Community Hospital  
 HINES—V.A. Hospital  
 HINSDALE—Hinsdale Sanitarium & Hospital  
 JOLIET—St. Joseph Hospital  
 MAYWOOD—Foster G. McGaw Hosp./Loyola  
                   University  
 NORTH CHICAGO—University of Health Sciences/  
                   Chicago Medical School  
 OAK LAWN—Christ Hospital  
 OAK PARK—West Suburban Hospital Association  
 PARK FOREST—Governors State University  
 PARK RIDGE—Lutheran General Hospital  
 PEORIA—Methodist Medical Center of Central Illinois  
                   St. Francis Hospital  
 QUINCY—St. Mary's Hospital  
 ROCKFORD—Rockford Memorial Hospital  
                   St. Anthony Hospital  
                   Swedish-American Hospital  
 SPRINGFIELD—St. John's Hospital  
                   Sangamon State University  
 URBANA—Carle Foundation Hospital  
 WAUKEGAN—St. Therese Hospital  
 WINFIELD—Central DuPage Hospital  
 NUCLEAR MEDICINE TECHNOLOGY  
 CHICAGO—Illinois Masonic Medical Center  
                   St. Mary of Nazareth Hospital Center  
 HINES—V. A. Hospital  
 PARK RIDGE—Lutheran General Hospital  
 PEORIA—St. Francis Hospital-Medical Center  
 RIVER GROVE—Triton College  
 OCCUPATIONAL THERAPIST  
 CHICAGO—University of Illinois College of Medicine  
 PHYSICAL THERAPIST  
 CHICAGO—Northwestern University Medical School  
                   University of Health Science/  
                   Chicago Medical School  
                   University of Illinois College of Medicine  
 RADIOGRAPHER  
 ARLINGTON HTS.—Northwest Community Hospital  
 BELLEVILLE—Belleville Area College  
 CARBONDALE—Southern Illinois University  
 CHAMPAIGN—Parkland College  
 CHICAGO—Central YMCA Community College  
                   Cook County Hospital  
                   DePaul University  
                   Henrotin Hospital  
                   Illinois Masonic Medical Center  
                   Louis A. Weiss Memorial Hospital  
                   Malcolm X Community College  
                   Michael Reese Hospital & Medical Center  
                   Provident Hospital & Training School  
                   Ravenswood Hospital Medical Center  
                   St. Anne's Hospital  
                   St. Joseph Hospital  
                   St. Mary of Nazareth Hospital Center  
                   South Chicago Community Hospital  
                   University of Illinois Hospital  
                   Wright Junior College  
 DANVILLE—Lake View Medical Center  
 DECATUR—Decatur Memorial Hospital  
 DIXON—Sauk Valley College  
 EAST PEORIA—Illinois Central College  
 ELGIN—St. Joseph Hospital  
 EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College  
 GLEN ELLYN—College of DuPage  
 GRAYSLAKE—College of Lake County  
 HINSDALE—Hinsdale Sanitarium & Hospital  
 KANKAKEE—Kankakee Community College  
 KEWANEE—Kewanee Public Hospital  
 MACOMB—McDonough District Hospital  
 MALTA—Kishwaukee College  
 MOLINE—Lutheran Hospital  
                   Moline Public Hospital  
 MORTON GROVE—Oakton Community College  
 NORMAL—Brokaw Hospital  
 OLNEY—Richland Memorial Hospital  
 PALOS HILLS—Moraine Valley Community College  
 PEORIA—St. Francis Hospital  
 QUINCY—Blessing Hospital  
                   St. Mary's Hospital  
 RIVER GROVE—Triton College  
 ROCKFORD—Rockford Memorial Hospital  
                   Swedish American Hospital  
 ROCK ISLAND—Rock Island Franciscan Hospital  
 SOUTH HOLLAND—Thornton Community College  
 SPRINGFIELD—Lincoln Land Community College  
                   Memorial Medical Center  
 RESPIRATORY THERAPIST  
 CHAMPAIGN—Parkland College  
 CHICAGO—Central YMCA Community College  
                   Malcolm X College  
                   Northwestern University Medical School  
                   University of Chicago Hospitals & Clinics  
 MOLINE—Lutheran Hospital  
 PALOS HILLS—Moraine Valley Community College  
 RIVER GROVE—Triton College  
 ROCKFORD—St. Anthony Hospital  
 SPRINGFIELD—Memorial Medical Center  
 RESPIRATORY THERAPY TECHNICIAN  
 CHAMPAIGN—Parkland College  
 CHICAGO—Metropolitan Group of Hospitals  
                   Northwestern Memorial Hospital  
                   University of Chicago Hospitals and Clinics  
 KANKAKEE—Kankakee Community College  
 MOLINE—Lutheran Hospital  
 OAK LAWN—Christ Hospital  
 PALOS HILLS—Moraine Valley Community College  
 QUINCY—St. Mary's Hospital  
 ROCKFORD—Swedish American Hospital  
 SPRINGFIELD—St. John's Hospital  
 WAUKEGAN—Victory Memorial Hospital  
 RADIATION THERAPY TECHNOLOGIST  
 CHICAGO—Chicago State University  
                   Michael Reese Hospital/City Wide College  
                   Rush-Presbyterian-St. Luke's Medical  
                   Center  
 ELGIN—St. Joseph Hospital  
 EVANSTON—Evanston Hospital  
                   St. Francis Hospital  
 HINES—V. A. Hospital  
 ROCKFORD—Swedish American Hospital  
 SPECIALIST IN BLOOD BANK TECHNOLOGY  
 CHICAGO—Michael Reese Hospital & Medical Center  
                   Mount Sinai Hospital Medical Center  
                   University of Illinois College of Medicine  
 PARK RIDGE—Lutheran General Hospital  
 SURGICAL TECHNOLOGIST  
 BELLEVILLE—Belleville Area College  
 CHAMPAIGN—Parkland College  
 EAST PEORIA—Illinois Central College  
 MOLINE—Moline Public Hospital  
 QUINCY—Blessing Hospital  
 RIVER GROVE—Triton College



# ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Representatives are

elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

## EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning

on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

## STATE OFFICERS 1980

*Governor*, JAMES R. THOMPSON, Rep., Chicago  
*Lieutenant Governor*, DAVE O'NEAL, Rep., Belleville  
*Secretary of State*, ALAN J. DIXON, Dem., Belleville  
*Comptroller*, ROLAND W. BURRIS, Dem., Chicago

*Treasurer*, JEROME COSENTINO, Rep., Palos Heights  
*Attorney General*, TYRONE FAYNOR, Rep., Evanston  
*Clerk of the Supreme Court*, CLELL L. WOODS, Springfield

## LEGISLATIVE BRANCH

### Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

### Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference

committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

### Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

## DEPARTMENT OF CHILDREN AND FAMILY SERVICES

160 North LaSalle Street, Room 1700, Chicago 60601  
One North Old State Capitol Plaza, Springfield 62706  
Gregory L. Coler, *Director*

### Director's Office

Iris Slack, Deputy Director for Policy and Plans  
Gordon Johnson, Deputy Director for Program Operations

Thomas Walsh, Deputy Director for Management and Budget  
Paul Freedlund, Special Assistant to the Director

## DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706  
160 N. La Salle St., Chicago, 60601  
Ivan Pavkovic, M.D., Acting Director  
Roalda J. Alderman, Associate Director for Alcoholism & Liaison to Dangerous Drugs Commission  
Richard E. Blanton, Ph.D., Associate Director, Developmental Disabilities  
Noble Emde, Administrator for Management Services  
Edwin Goldman, Administrator for Community Services & Interagency Affairs

### Office of the Director

Robert E. Lanier, Special Assistant  
Maureen D. Mudron, Acting General Counsel  
Douglas I. Carey, Legislative Liaison  
David B. Thomas, Chief Auditor  
Dorothy Ackman, Administrative Assistant  
E. Allen Bernardi, Executive Assistant  
Thomas Self, Chief, Systems Design & Evaluation  
David Klass, M.D., Director of Research & Coordinator of Evaluation  
Jack Saporta, Ph.D., Chief, Manpower, Training & Education  
Donald A. Neltnor, Acting Chief, Public Relations Office

**Director's Executive Council Members and Regional Administrators**  
Richard E. Blanton, Ph.D.

Noble Emde  
Douglas I. Carey  
Edwin Goldman  
Roalda Alderman  
John Meyer, Manager, IDMHDD Field Services  
Donald Hart, Region 1A Administrator, Rockford  
James Dalzell, Region 1B Administrator, Peoria  
Jefferson McAlpine, M.D., Region 2 MI-Alcoholism Administrator, Chicago  
Arthur Dykstra, Jr., Region 2 Developmental Disabilities Administrator, Tinley Park  
Ugo Formigoni, M.D., Region 3A Administrator, Springfield  
J. Gregory Langan, Ed.D., Region 3B Administrator, Decatur  
Joseph Gruber, Ph.D., Region 4 Administrator, Alton  
Ronald G. Bittle, Ph.D., Region 5 Administrator, Anna

## STATUTORY BOARDS AND COUNCILS

### 1. Commission on Mental Health and Developmental Disabilities

Sen. Jack Schaffer, Crystal Lake, *Chairman*  
Rep. Helen Satterthwaite, Champaign, *Vice-Chairman*  
Mrs. Rose Poelvoorde, Silvis, *Secretary*  
Mrs. Judy Buchanan, Bloomington  
Hon. John Carroll, Park Ridge  
Mrs. Carolyn Chapman, Belleville  
Sen. Earlean Collins, Chicago  
Sen. Vince DeMuzio, Carlinville  
Dr. Vernon Frazee, Lincolnwood  
Rep. Mary Jeanne Hallstrom, Evanston  
Mr. Robert Lambourn, McHenry  
Rep. Richard Mugalian, Chicago  
Sen. Richard Newhouse, Chicago  
Sen. John Nimrod, Park Ridge  
Sen. Frank Ozinga, Evergreen Park  
Rep. Lee Preston, Chicago

Rep. James Reilly, Jacksonville  
Hon. Esther Saperstein, Chicago  
Rep. Sam Vinson, Clinton  
Margaret M. Hastings, Chicago, *Exec. Dir.*

### 2. Psychiatric Advisory Council

Ivan Pavkovic, M.D., *Chairman*  
Robert A. deVito, M.D., Chicago  
Jan Fawcett, M.D., Chicago  
Daniel X. Freedman, M.D., Chicago  
Arthur Greenfield, D.O., Chicago  
Harold M. Visotsky, M.D., Chicago  
Daniel Offer, M.D., Chicago  
George H. Pollock, M.D., Chicago  
Lester H. Rudy, M.D., Chicago  
Michael Taylor, M.D., North Chicago  
Harold M. Visotsky, M.D., Chicago  
Jack Weinberg, M.D., Chicago



## NON-STATUTORY COUNCILS

### 1. Citizens' Advisory Council on Alcoholism

Maxine Rosenbarger, Ph.D., Carbondale, *Chairman*  
 James W. West, M.D., Evergreen Park  
 Phillip E. Anderson, Danville  
 John C. Clarno, DDS, Peoria  
 Gregory Coler, Springfield  
 Byron J. Francis, M.D., Springfield  
 Gayle M. Franzen, Springfield  
 LaVerne M. Hawes, Chicago  
 James Jeffers, Chicago  
 Geraldine H. Jenkins, Ph.D., E. St. Louis  
 William L. Kempiners, Springfield  
 Robert S. Kincheloe, Chicago  
 Mary Louise Kinsman, Glenwood  
 Jeffrey C. Miller, Chicago  
 Julio Cesar Montoya, Chicago  
 James H. Oughton, Jr., Dwight  
 William J. Penn, Rockford

Ms. Carole Schuft, Decatur  
 John Smith, Peoria  
 W. David Steed, M.D., Oak Park  
 William Thomas, Jr., M.D., Chicago

### 2. Citizens' Advisory Council for Community Services

Philip Carlson, Peoria, *Chairman*  
 William N. Frayser, Broadview  
 Ms. Peggy B. Fultz, Highland Park  
 Ms. Elizabeth Gatlin, Evanston  
 Helen Hudlin, Ph.D., East St. Louis  
 Thomas K. Janssen, Nashville  
 Arnold Levin, Ph.D., Chicago  
 Paul B. Musgrove, Peoria  
 Robert Norris, Evergreen Park  
 Samuel A. Patch, Chicago  
 Brockman Schumacher, Ph.D., Carbondale  
 Sister Chaminade Kelley, Springfield

## DANGEROUS DRUGS COMMISSION

The Drug Abuse Offense and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs Commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Treatment modalities of programs receiving Dangerous Drugs Commission funds include methadone maintenance, both residential and out-patient; drug free residential and out-patient therapy, and hot-line and crisis referral services. In addition to treatment funding, the Dangerous Drugs Commission supports drug counselor

training for previously drug dependent clients as well as clinical staff training.

Since reliable and timely data are essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Section of the Commission continually collects, analyzes and applies data concerning clinical operations (medical work-ups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages.) The Section also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program resources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina City Office Building, 300 N. State St., Suite 1500, Chicago, 60610. Phone (312) 822-9860.

Ivan Pavkovic, M.D., Chicago, *Acting Chairman*  
 Thomas Kirkpatrick, Jr., Chicago, *Exec. Director*  
 Gregory L. Coler, Springfield  
 Gayle Franzen, Springfield  
 Donald Gill, Springfield  
 James Jeffers, Chicago  
 William Kempiners, Springfield  
 Jeffrey Miller, Chicago  
 Robin Morgenstern, Chicago  
 Judge Eugene Pincham, Chicago  
 Joseph Skom, M.D., Chicago  
 James Zagel, Chicago

### Dangerous Drugs Advisory Council

Rep. L. Michael Getty, Dolton, *Chairman*  
 Mrs. Roalda J. Alderman, Chicago  
 David Bingham, Oak Park  
 David Blumenfeld, Esq., Chicago  
 Herschel Browns, M.D., Chicago  
 Supt. Richard Brzezczek, Chicago  
 Emanuel M. Cannonito, Esq., Blue Island  
 Bernard Carey, Esq., Chicago

Sen. John A. Davidson, Springfield  
 Sen. John D'Arco, Chicago  
 Edward Duffy, R.Ph., Downers Grove  
 Ms. Joan Elbow, Galesburg  
 Norman Garfinkel, R.Ph., Oak Park  
 Chief Charles A. Gruber, Quincy  
 Rep. George Hudson, Hinsdale  
 Sen. Roger Keats, Kenilworth  
 Hon. Benjamin S. Mackoff, Chicago  
 Michael M. Mihm, Esq., Peoria  
 Hugo Muriel, M.D., Chicago  
 Sen. Dawn Clark Netsch, Chicago  
 James Nowlan, Springfield  
 Don Paull, Ph.D., Chicago  
 Roger Quick, Oak Brook  
 David B. Selig, Esq., Wilmette  
 Harry Sholl, Lake Forest  
 Donna Simonson, Springfield  
 Rep. Roger Stanley, Streamwood  
 Jay Ulanek, Chicago  
 Robert B. Uretz, Ph.D., Chicago  
 Rep. Leroy M. VanDuyne, Joliet

## DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield, 62701  
Jeffrey C. Miller, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

### Administrative Staff

David L. Daniel, Assistant Director  
H. Dickson Buckley, Legislative Liaison  
Johnetta W. Jordan, Chief, Office of Public Information  
Jane Snowden, Special Assistant to the Director  
Robert G. Wessel, Chief, Office of Personnel & Employee Relations  
Verne H. Evans, Chief, Office of Hearings/Recoveries  
David Rakov, General Counsel, Office of Counseling/Litigation  
Daniel McCarthy, Chief Auditor  
Mary Ann Langston, Policy & Planning Administrator  
Norman Ryan, General Services Administrator  
Michael Belletire, Operations Administration Administrator  
Peter Bloomsburgh, Acting Medical Programs Administrator

### Legislative Advisory Committee on Public Aid

Sen. Richard H. Newhouse, Chicago, *Chairman*  
Sen. Don A. Moore, Midlothian, *Vice-Chairman*  
Rep. Charles M. Campbell, Danville, *Secretary*  
Sen. Frank M. Ozinga, Evergreen Park  
Sen. Jack Schaffer, Crystal Lake  
Sen. Harold Washington, Chicago  
Sen. Don Wooten, Rock Island  
Rep. Charles E. Gaines, Chicago  
Rep. Emil Jones, Chicago  
Rep. Josephine Oblinger, Sherman  
Rep. Taylor Pouncey, Chicago  
Rep. J. Glenn Schneider, Wheaton

### State Medical Advisory Committee

Fred Z. White, M.D., Chillicothe, *Chairman*  
Elchanan Golan, M.D., Chicago  
Donald Hoard, M.D., Chicago  
F. Paul LaFata, M.D., Springfield  
George T. Mitchell, M.D., Marshall  
Robert C. Muehrcke, M.D., Oak Park  
Jacob E. Reisch, M.D., Springfield  
Fred A. Tworoger, M.D., Chicago  
Herbert Dexheimer, M.D., Belleville  
A. S. Norris, M.D., Springfield  
Dennis A. Reter, M.D., Canton

## DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706

William L. Kempiners, *Director*

Robert S. Gleason, *Legal Advisor*  
Robert Hedges, *Legislative Liaison*  
Walter DeWeese, *Internal Auditor*

B. Smith Hopkins, *SHCC*  
Raymond Passeri, *HFPB*

### Medical Determination Board Nominees

*These nominees have been approved by the Governor. Confirmation is expected by the Senate when the legislature reconvenes after the November elections.*

Audley F. Connor, M.D., Chicago  
Richard Suhs, M.D., Springfield  
Noel Bass, M.D., Joliet  
J. Robert Buchanan, M.D., Chicago  
Richard Moy, M.D., Springfield  
Hugh Rohrer, M.D., Peoria  
Samuel Andelman, M.D., Skokie

### Administration

Deputy Director  
Fred H. Uhlig  
Legal, Legislative and Administrative Staff  
Harry Bostick  
Division of Budget & Fiscal Operations  
Dave King  
Division of Education & Information  
Stanley Miles

Division of Electronic Data Processing  
Thomas Stuckey  
Division of Public Health Laboratories  
Dr. Hugh-Bert Ehrhard  
Division of Vital Records  
Aaron Vangeison  
Division of General Services  
Joseph Schweska

### Health Services

Associate Director  
Shirley Reed  
Division of Local Health Administration  
Alvin Grant  
Division of Dental Health  
Dr. R. Kuthy  
Division of Disease Control  
Byron Francis, M.D.  
Division of Emergency Medical Service and Highway Safety  
Leonard Kutilek  
Division of Family Health  
Dr. B. Turnock



Division of Implied Consent  
Angelo Garella  
Division of Health Promotion and Screening  
James Nelson

#### Health Regulation

Associate Director  
Patricia A. Nolan, M.D.  
Division of Food and Drugs  
Dr. Roy Upham  
Division of Environmental Health and Sanitation  
Robert Wheatley  
Division of Milk Control  
Harold McAvoy  
Division of Radiation Protection  
Maurice Neuweg  
Division of Long-Term Care  
William Irvine  
Division of Engineering  
Jerry Ackerman

Division of Nuclear Safety  
Gary Wright  
Division of Hospitals and  
Ambulatory Health Programs  
Michael Grobsmith  
Division of Development and Construction  
Aden Clump  
Division of Administration  
Betty J. Williams

#### Health Planning

Associate Director  
Harold Ziebell  
Division of Plan Coordination  
Dr. John Cotner  
Division of Facilities Development  
Raymond Passeri  
Division of Health Information and Evaluation  
Dr. Charles Bennett (*Acting*)

### STATUTORY BOARDS AND COMMISSIONS

(Allied with Public Health Operations)

#### Long-Term Care Facility Advisory Board

Peter Bloomsburgh, Springfield  
Leroy Cohnen, Springfield  
Mary Gibb, Evanston  
Carolyn Greider, Springfield  
Robert Lanier, Springfield  
Peter Mule, Mundelein  
Marie Sadlick, Chicago  
Ray Unterbrink, Springfield  
Patricia A. Nolan, M.D., Chairperson *ex officio*

#### Drivers License Medical Advisory Board

James S. Ward, Peoria  
Psychiatrist  
Joel Kaplan, M.D., Chicago  
Ophthalmologist  
James F. Kurtz, M.D., LaGrange  
Orthopedic Surgeon  
Frank Norbury, M.D., Jacksonville  
Internist  
Ronald P. Pawl, M.D., Chicago  
Neurological Surgery  
Paul Schmidt, M.D., Galva  
Family Physician  
Alan J. Stutz, M.D., Springfield  
Therapeutic Radiologist

#### Hazardous Substances Advisory Council

Ken Cole, Chicago  
Jiffy Johnson, Springfield  
Edward F. O'Toole, Chicago  
Richard C. Reinke, Lemont

#### Ambulatory Surgical Treatment Center Licensing Board

Edward A. Brunner, M.D., Skokie  
Dorothy L. Caballero, R.N., Chicago  
Jon M. Doshier, Havana  
Donald W. Hugar, D.P.M., River Forest

Donald Jerome, M.D., Belleville  
Irwin N. Lebow, D.D.S., Normal  
William D. McNobola, M.D., Wilmette  
Peggy Montes, Chicago  
Dr. Natalie Stephens, Chicago  
Ruth Surgal, Chicago  
Caryl Towsley Moy, Springfield

#### Clinical Laboratory and Blood Bank Advisory Board

Densil A. Brown, Prospect Heights  
Gerald G. Hoffman, M.D., Lake Forest  
Alfred J. Kiessel, M.D., Decatur  
Wayne N. Leimbach, M.D., Aurora  
Hugh J. McDonald, Sc.D., Skokie  
Mrs. Dorothea M. Prevo, M.S., Glencoe

#### Hospital Licensing Board

Elmer E. Abrahamson, Chicago  
Sister Ann Bailey, Springfield  
John Rice, Winfield  
Robert F. Schinderle, Plainfield  
Robert E. Lanier, Springfield  
William M. Lees, M.D., Lincolnwood  
Earl D. Long, D.C., Marion  
M. Frances Nash Terrell, East St. Louis  
Robert H. Reeder, M.D., St. Charles  
June Werner, R.N., Evanston  
Betty Meents, Watseka

#### Radiation Protection Advisory Council

Larry Lanzl, Ph.D., Chicago, *Chairman*  
Howard Burkhead, M.D., Evanston  
Jerome J. Steerman, Urbana  
Seymour Yale, D.D.S., Chicago  
F. E. Demaree, Chicago  
John Rust, D.V.M., Chicago  
Lawrence Levin, Lincolnwood  
Director of Labor, *ex-officio*  
Chairman, Commerce Commission, *ex-officio*

#### Illinois Chronic Renal Disease Advisory Committee

Byron J. Francis, M.D., Springfield, *Chairman*  
 Arthur E. Abney, Chicago  
 Edmund J. Lewis, M.D., Chicago  
 David P. Earle, M.D., Chicago, *Consultant*  
 Alan Kanter, M.D., Chicago  
 Robert M. Kark, M.D., Chicago, *Consultant*  
 Robert H. Pflederer, M.D., Peoria  
 Franklin D. Schwartz, M.D., Chicago  
 Francisco DelGreco, M.D., Chicago  
 George Dunea, M.D., Chicago  
 Alan G. Birtch, M.D., Springfield  
 Olga Jonasson, M.D., Chicago  
 Dean Stanley, Chicago  
 Ewald T. Sorenson, M.D., Rockford  
 Harold Schwartz, Lincolnwood  
 Richard Bilinsky, M.D., Springfield

#### Immunization Advisory Committee

Mark Lepper, M.D., Hinsdale, *Chairman*  
 Joseph R. Kraft, M.D., Chicago  
 David Greeley, M.D., Chicago  
 Byron J. Francis, M.D., Springfield, *Technical Secretary*  
 James P. Paulissen, M.D., Wheaton  
 Daniel J. Pachman, M.D., Chicago  
 Loren Boon, M.D., Danvers

#### Health Facilities Planning Board

Marjorie E. Albrecht, Princeton  
 Donovan F. Gardner, Pontiac  
 Nancy B. Jefferson, Chicago  
 Alexander Goldstein, M.D., Harrisburg  
 Harry S. Kurchenbaum, Chicago  
 Philip R. Lescohier, Clarendon Hills  
 James E. Mann, Chicago  
 Harold Maysent, Chicago  
 Joseph C. Mudd, Peoria  
 C. Johnathan Shattuck, Wilmette  
 Pam Taylor, Danville  
 John F. Wayland, LaSalle  
 Bernard Weiner, Kankakee  
 William L. Kempiners, Springfield, *ex-officio*  
 Jeffrey Miller, Springfield, *ex-officio*

#### Advisory Board of Necropsy Service to Coroners

Dan H. Brintlinger, Decatur  
 Thomas H. Hanlon, Arlington Heights  
 Welland Hause, M.D., Decatur  
 Ronald Kowalski, M.D., Peoria  
 Richard H. Lynch, Charleston  
 James D. Radden, Belleville  
 Kae Rairdin, Arlington Heights  
 Norman T. Richter, Springfield  
 Grover L. Seitzinger, M.D., Danville

#### Statewide Health Coordinating Council

Samuel Andelman, M.D., Skokie  
 Barbara Anderson, Coal Valley  
 Dave Bauer III, Wheaton  
 Sally D. Berger, Chicago  
 Paul R. Booth, Chicago  
 Eli L. Borkon, M.D., Carbondale  
 Curtis K. Brady, Bourbonnais  
 Warren J. Brodine, Chicago  
 Frank Campbell, Peoria  
 Kenneth W. Cote, Kankakee  
 Doris Dalton, Joliet

Dale Drake, D.D.S., Belvidere  
 Constance Duffy, Oak Park  
 Linda Edwards, R.N., Oak Park  
 Ted Eilerman, Granite City  
 John E. Ekblad, Rock Island  
 Wilbert Exline, Moline  
 John R. Fears, Hines  
 Robert Fox, D.D.S., Bourbonnais  
 William Frayser, Broadview  
 Marulla "Sally" Friedrich  
 Edward Glover, D.C., Peoria  
 Virginia M. Hayter, Hoffman Estates  
 Joseph Heimann, Germantown  
 Henrietta Herbolzheimer, M.D., Chicago  
 Donald M. Hillenmayer, Arlington Heights  
 B. Smith Hopkins, M.D., Urbana  
 Mary Janka, Chicago  
 Sara Kessler, Decatur  
 Mary Louise Kinsman, Glenwood  
 Joyce Klug, Lake Zurich  
 Ms. Nancy Lane, Mattoon  
 Charles Lipe, Springfield  
 Cleveland Matthews, Carbondale  
 David Musgrave, Robinson  
 Edward Palmer, Chicago  
 Robert Quisenberry, Emden  
 J. Allan Roney, Springfield  
 Ophelia Gonzalez-Ross, Chicago  
 Robert Schmidt, O.D., Pekin  
 Margaret Setzekorn, Mt. Vernon  
 Douglas Spencer, Springfield  
 Margaret Summers, New Berlin  
 John A. Taft, Jr., St. Charles  
 Sam Vinson, Clinton  
 Barbara Volkmann, Chicago  
 Glen Wiegold, Springfield  
 Laurence D. Worden, Rockford

#### Illinois Health Facilities Authority

George Phillips, Chicago, *Executive Director*  
 Francis C. Taylor, Chicago, *Assoc. Exec. Dir.*  
 Stanford Glass, Winnetka, *Chairman*  
 Roger D. Herrin, D.P.M., Harrisburg, *Vice Chairman*  
 Louis G. Alexander, Chicago  
 Charles E. Hayes, Arlington Heights  
 Robert Kane, M.D., Herrin  
 Irene Mills, Decatur  
 Joseph S. Wright, Jr., Chicago

#### Alcoholism Treatment Licensure Program Advisory Board

Patrick Cullinane, Carbondale, *Chairman*  
 Theodor Bernardy, M.D., Springfield  
 Lee Gladstone, M.D., Chicago  
 Mark D. Godley, Marion  
 Geraldine M. Jenkins, E. St. Louis  
 Bageshwari Parihar, Chicago  
 Nick John Piazza, Jr., Jacksonville  
 John V. Reese, Elgin  
 Betty Strickland, Park Ridge  
 Patricia A. Nolan, M.D., *Chairperson, ex-officio*  
 Ruth K. Holl, *ex-officio*

Dept. of Mental Health and Developmental Disabilities

#### Pre-Hospital Emergency Care Advisory Board

Richard Beilfuss, Glenview  
 William Culbreth, Central



Steve Kirk, R.N., Springfield  
 Kathleen LaGreca, R.N., McHenry  
 Barry Millman, Chicago  
 Louis A. Reibling, Ph.D., Belleville  
 Linda Riseman, Chatham  
 Allen Spacone, M.D., Oak Brook  
 Susan Weed, Chicago  
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 William Rushakoff, Chicago  
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 Gwendolyn White, M.D., Springfield

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 Act, HB 106, 107; P.A. 84-78, 84-79**

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 Martin E. Levitt, D.O., Chicago  
 Richard H. Moy, M.D., Springfield  
 Jorge Prieto, M.D., Chicago  
 Genevieve Alloy Watson, Peoria  
 Norman F. Webb, Chicago  
 Fred Z. White, M.D., Chillicothe

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(Allied with Public Health Operations)

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 Olga Brolnitsky, M.D., Chicago  
 Hugh Rohrer, M.D., Peoria  
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 Rosielyn Lassiter, Chicago  
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 Kenneth Mangan, Ed.D., Jacksonville

Ralph Naunton, M.D., Chicago  
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 Paul Rittmanic, Ph.D., Rockford  
 Ann Russell, Chicago  
 George Skertich, South Holland  
 William P. Johnson, Ph.D., Jacksonville  
 Penny Meyers, Skokie  
 Terry Bourret, Springfield

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 Nancy Drake, Springfield  
 Anthony P. Ferracane, Harvey  
 Norbert Freinkel, M.D., Chicago  
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 Robert Jackson, East Peoria  
 Sheila Lyne, R.S.M., Chicago  
 Marilyn Meyer, R.N., Effingham  
 Arthur Rubenstein, M.D., Chicago  
 Sister Paulette O'Connell, Chicago  
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 Max Stachura, M.D., Chicago  
 Donna Stoner, Decatur  
 Howard Vernof, M.D., Evanston  
 Stephen A. Weinberg, D.P.M., Buffalo Grove  
 Jeanette White, R.D., Chicago  
 Jerry Woolley, Chicago

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 Nathaniel I. Berlin, M.D., Chicago  
 Milton F. Darr, Jr., Chicago  
 Frank R. Hendrickson, M.D., Chicago  
 Paul Q. Peterson, M.D., M.Ph., Chicago  
 John E. Ultmann, M.D., Chicago  
 Irving J. Weigensberg, M.D., Peoria

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 Elmer Johnson  
 Jacqueline Kinder  
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 Roosevelt D. Collins, D.D.S., Chicago  
 Kathleen B. Fralish, Ph.D., Carbondale  
 Leslie E. Long, D.D.S., Joliet  
 Mrs. Verlene Mullens, Hopkins Park

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**POISON CONTROL CENTERS IN ILLINOIS**

For information contact:  
 Division of Emergency Medical Services & Highway Safety  
 Illinois Department of Public Health  
 525 W. Jefferson  
 Springfield, 62761  
 Phone: (217) 785-2080

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**APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS**

Illinois Department of Public Health  
 Division of Disease Control  
 For information contact:  
 Mrs. Ruth S. Shriner, ACSW—Coordinator Direct Services Programs  
 Illinois Department of Public Health  
 Room 150, 535 West Jefferson Street, Springfield 62706  
 Phone (217) 782-3303

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**DEPARTMENT OF REGISTRATION AND EDUCATION**

320 W. Washington Street, Springfield 62786  
 55 East Jackson Boulevard, Chicago 60604  
 Gary L. Clayton, *Director*  
 Robert C. Maple, *Deputy Director*  
 Kenneth A. Padgham, Jr., *General Counsel*  
 Louis R. Fine, *Chief Regulatory Officer*  
 Charles T. McHugh, M.D., *Medical Coordinator*  
 Louis R. Vitullo, *Chief of Medical Investigations*

The department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee appointed by the director of the Department operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making



recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

### Medical Examining Committee

Richard Rovner, M.D., Chicago, *Chairperson*  
Mays Maxwell, M.D., E. St. Louis, *Vice Chairman*  
Paul Tullio, D.C., Glen Ellyn, *Secretary*  
Robert Behmer, M.D., Rockford

Kenneth G. Eggen, M.D., Chicago  
John Patton, D.O., LaSalle

### Medical Disciplinary Board

James B. Williams, M.D., Chicago, *Chairman*  
Sam Brinkley, D.C., Alton, *Vice Chairman*  
George Caleel, D.O., Chicago, *Secretary*  
Willard C. Scrivner, M.D., Belleville  
Helen R. Beiser, M.D., Chicago  
Charles Jannings, M.D., Fairfield  
John Gregorio, M.D., River Forest

## MEDICAL PRACTICE ACT

*Service on medical committees—Exemption from civil liability.* § 2b. While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Care Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or the improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct. *Amended by P.A. 79-1434 § 7, eff. Sept. 19, 1976; P.A. 80-771, § 3, eff. Oct. 1, 1977.*

*Practice by person licensed in another state pending examination.* § 2c.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

- (a) the expiration of 6 months after the filing of such written application, or
- (b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or
- (c) the withdrawal of the application. *(Added by Act approved July 26, 1971)*

### *Dispensing drugs or medicine—Label.] § 2d.*

Any person licensed under this act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dis-

pensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. *Formerly § 2c. Renumbered § 2d by P.A. 77-1849, § 3, eff. July 1, 1972.*

§ 5. *Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department. The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing.

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five



years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years' course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1988, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years' course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service

requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1988, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1988, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (*Added by Act approved Sept. 7, 1974*).

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to



graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment.

#### CONTINUING EDUCATION

Continuing education—Recommendations by Examining Committee]

§ 5.1. The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

- (1) Develop practical and meaningful criteria for defining and describing continuing education requirements which meet, but are not limited to, the following specifications:
  - (a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.
  - (b) Compatible with existing requirements of licensing agencies in other states.
  - (c) Compatible with the requirements of medical specialty boards for recertification of specialty status.
  - (d) Compatible with the continuing education requirements developed by national medical specialty societies.
  - (e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.
  - (f) Provides for differing requirements for licenses engaged in other than direct patient care (ex-

ample: educators, researchers and those engaged in medical administration).

- (g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.
- (2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:
    - (a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.
    - (b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.
    - (c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.
    - (d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.
    - (e) Exemption from legal prosecution of all persons responsible for action taken under the program.
    - (f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.
    - (g) Procedures for surveying and evaluating the effectiveness of the program.
    - (h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.
    - (i) Provision for an extension of license during any renewal period when a compliance audit of continuing education credits of any person licensed under this Act is undertaken. Such extension shall be for a period not to exceed 3 months within which such compliance audit shall be completed. Orderly procedures shall be developed by the Department for adequate notification and methods of determining compliance with any audit undertaken by the Department.
    - (j) Orderly procedures for establishing requirements for reinstatement of any license not renewed because the holder of such license has failed to demonstrate compliance with the continuing education requirements of the Rules and Regulations promulgated for the administration of this Section.
  - (3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.
  - (4) Develop an advisory panel for each category of licensee to advise and assist the department in developing and application of continuing education criteria, administrative procedures and policy.
  - (5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality. The Department shall enforce these requirements; however, the Department shall be empowered to waive

enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality. *Amended by P.A. 80-1203, § 1, eff. June 30, 1978.*

Section 14. (A) *Renewal.* Every certificate of registration issued under this Act shall expire on July 31 of each even-numbered year. The holder of a certificate of registration may renew such certificate during the month preceding the examination date thereof by paying the required fee.

**REVOCATION OR SUSPENSION OF LICENSE, CERTIFICATE, OR PERMIT—PROBATION OR OTHER DISCIPLINARY ACTION**

§ 16. The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon any of the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:

(a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;

(b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing, and regulation of hospitals" approved July 1, 1953, as heretofore or hereafter amended; or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Conviction in this or another State of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust;

3. Gross or repeated malpractice resulting in serious injury or death of a patient;

4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation,

or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

6. Habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties;

7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;

8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery or in passing an examination therefor, or wilful and fraudulent violation of the rules and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill, or of the efficacy or value of one's medicine, treatment or remedy therefor;

10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;

11. Revocation or suspension of a medical license in a sister state;

12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;

13. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act", as now or hereafter amended, or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of 2 or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each.

14. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation.

15. Abandonment of a patient.

16. The use or prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.

17. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.



18. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.

19. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.

20. Willfully making or filing false records or reports in his practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code.

21. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.

22. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.

23. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Public Aid under the Public Aid Code.

24. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction.

25. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license or certificate on any of the foregoing grounds, except the ground numbered 8 (fraudulent grounds excepted) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license or certificate was without the State of Illinois shall not be included within the 3 years.

The entry of an order or judgment by any circuit court establishing that any person holding a license or certificate under this Act is a person in need of mental treatment operates as a suspension of that license or certificate. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

*Amended by P.A. 81-1136, § 1, eff. July 1, 1980.*

#### ADVERTISING

§ 16.01. Any person licensed under this Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered. Such advertising shall be limited to the following information:

(1) Publication of the person's name, title, office hours, address and telephone number;

(2) Information pertaining to his areas of specialization, including appropriate board certification or limitation of professional practice;

(3) Information on usual and customary fees for routine professional services offered which such information shall include notification that fees may be adjusted due

to complications or unforeseen circumstances;

(4) Announcement of the opening of, change of, absence from, or return to business;

(5) Announcement of additions to or deletions from professional licensed staff;

(6) The issuance of business or appointment cards.

It is unlawful for any person licensed under this Act to use testimonials or claims of superior quality of care to entice the public. It shall be unlawful to advertise fee comparisons of available services with those of other persons licensed under this Act.

This Act does not authorize the advertising of professional services which the offeror of such services is not licensed to render. Nor shall the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.

*Amended by P.A. 81-1136, § 1, eff. July 1, 1980.*

#### MEDICAL DISCIPLINARY BOARD

*Illinois State Medical Disciplinary Board. § 16.02.*

There is hereby created the Illinois State Medical Disciplinary Board, (hereinafter referred to as the "Board"). The Board shall consist of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years, two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willful neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecutive four year terms.

In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented. In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.

c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secre-



tary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.

d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the Board. Any action taken by the Board under this Act may be authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.

e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education, hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.

f. The Director shall, in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board.

The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.

g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall:

(1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.

h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

*Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

*Suspension or revocation of license or certificate—*

*Investigation—Notice—Hearing.] § 17.01.* Upon the motion of either the Department or the Board or upon the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for suspension or revocation under Section 16 of this Act, the Board shall investigate the actions of any person, so accused who holds or represents that he holds a license

or certificate. Such person is hereinafter called the accused.

The Department shall, before suspending, revoking, placing on probationary status, or taking any other disciplinary action as the Department may deem proper with regard to any license or certificate, at least 30 days prior to the date set for the hearing, notify the accused in writing of any charges made and the time and place for a hearing of the charges before the Board, direct him to file his written answer thereto to the Board under oath within 20 days after the service on him of such notice and inform him that if he fails to file such answer default will be taken against him and his license or certificate may be suspended, revoked, placed on probationary status, or have other disciplinary action, including limiting the scope, nature or extent of his practice, as the Department may deem proper taken with regard thereto.

Such written notice and any notice in such proceedings thereafter may be served by delivery of the same personally to the accused person, or by mailing the same by registered or certified mail to the address last theretofore specified by the accused in his last notification to the Department.

*Amended by P.A. 81-302, § 1, eff. Jan. 1, 1980.*

*Hearings by board—Continuance—Failure to file answer—Disciplinary action—Temporary suspension of license without hearing.] § 17.02.* At the time and place fixed in the notice, the Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. The Board may continue such hearing from time to time. If the Board is not sitting at the time and place fixed in the notice or at the time and place to which the hearing has been continued, the Department shall continue such hearing for a period not to exceed 30 days.

In case the accused person, after receiving notice, fails to file an answer, his license or certificate may in the discretion of the Director, having received first the recommendation of the Board, be suspended, revoked, placed on probationary status, or the Director may take whatever disciplinary action as he may deem proper, including limiting the scope, nature, or extent of said person's practice, without a hearing, if the act or acts charged constitute sufficient grounds for such action under this Act.

The Board has the authority to recommend to the Director that probation be granted or that other disciplinary action, including the limitation of the scope, nature or extent of a person's practice, be taken as it deems proper. If disciplinary action other than suspension or revocation is taken, the Board may recommend that the Director impose reasonable limitations and requirements upon the accused registrant to insure compliance with terms of the probation or other disciplinary action including, but not limited to, regular reporting by the accused to the Department of his actions, placing himself under the care of a qualified physician for treatment, or limiting his practice in such manner as the Director may require.

The Director may temporarily suspend the license of a physician without a hearing, simultaneously with the institution of proceedings for a hearing provided under this Section if the Director finds that evidence in his possession indicates that a physician's continuation in practice would constitute an immediate danger to the public. In the event that the Director suspends, tem-



porarily, the license of a physician without a hearing, a hearing by the Board must be held within 15 days after such suspension has occurred.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Subpoena of witnesses—Administration of oath.] § 17.03* The Board or Department has power to subpoena and bring before it any person in this State and to take testimony either orally or by deposition, or both, with the same fees and mileage and in the same manner as is prescribed by law for judicial procedure in civil cases.

The Director, Assistant Director, Superintendent of Registration and any member of the Board each have power to administer oaths at any hearing which the Board or Department is authorized by law to conduct.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Attendance of witnesses and production of books and papers.] § 17.04* Any circuit court upon the application of the accused person or complainant or of the Department or Board, may order the attendance of witnesses and the production of relevant books and papers before the Board in any hearing relative to the application for or refusal, recall, suspension or revocation of a license or certificate. The court may compel obedience to its order by proceedings for contempt.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Record of proceedings.] § 17.05* The Department, at its expense, shall provide a stenographer to take down the testimony and preserve a record of all proceedings at the hearing of any case wherein a license or certificate may be revoked, suspended, placed on probationary status, or other disciplinary action taken with regard thereto. The notice of hearing, complaint and all other documents in the nature of pleadings and written motions filed in the proceedings, the transcript of testimony, the report of the Committee and the orders of the Department constitute the record of such proceedings. The Department shall furnish a transcript of such record to any person interested in such hearing upon payment therefor of one dollar per page for each original transcript and 50¢ per page for each carbon copy thereof ordered with the original; except that the charge for any part of such transcript ordered and paid for previous to the writing of the original record thereof shall be 50¢ per page for each carbon copy.

*Amended by P.A. 77-2829, § 34, eff. Dec. 22, 1972; P.A. 78-255, § 61, eff. Oct. 1, 1973.*

*Report of findings and recommendations—Motion for Rehearing—Certificate of order of revocation, suspension, or other disciplinary action.] § 17.06.* The Board shall present to the Director a written report of its findings and recommendations. A copy of such report shall be served upon the accused person, either personally or by registered or certified mail. Within 20 days after such service, the accused person may present to the Department his motion in writing for a rehearing, which written motion shall specify the particular ground therefor. If the accused person orders and pays for a transcript of the record as provided in Section 17.05, the time elapsing thereafter and before such transcript is ready for delivery to him shall not be counted as part of such 20 days.

At the expiration of the time allowed for filing a motion for rehearing the Director may take the action recommended by the Board. Upon the suspension, revocation, placement on probationary status, or the taking of any other disciplinary action, including the limiting of the scope, nature, or extent of one's practice, deemed proper by the department, with regard to the license,

certificate or state hospital permit, the accused shall surrender his license or certificate to the Department, if ordered to do so by the Department, and upon his failure or refusal to do so, the Department may seize the same.

Each certificate of order of revocation, suspension, or other disciplinary action shall contain a brief, concise statement of the ground or grounds upon which the Department's action is based, as well as the specific terms and conditions of such action. This document shall be retained as a permanent record by the Board and the Director.

In those instances where an order of revocation, suspension, or other disciplinary action has been rendered by virtue of a physician's physical illness, including, but not limited to deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill, or safety, the Department shall only permit this document, and the record of the hearing incident thereto, to be observed, inspected, viewed, or copied pursuant to court order.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Restoration of license or certificate.] § 17.07* At any time after the suspension, revocation, placing on probationary status, or taking disciplinary action with regard to any license or certificate, the Department may restore it to the accused person, or take any other action to reinstate the license to good standing, without examination, upon the written recommendation of the Board.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Review under Administrative Review Act—Venue.] § 17.08* All final administrative decisions of the Department are subject to judicial review pursuant to the provisions of the "Administrative Review Act", approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined as in Section 1 of the "Administrative Review Act".

Such proceedings for judicial review shall be commenced in the Circuit Court of the County in which the party applying for review resides; but if such party is not a resident of this State, the venue shall be in Sangamon County.

The Department shall not be required to certify any record to the Court or file any answer in Court or otherwise appear in any Court in a Judicial review proceeding, unless there is filed in the Court with the complaint a receipt from the Department acknowledging payment of the costs of furnishing and certifying the record which costs shall be computed at the rate of 20 cents per page of such record. Exhibits shall be certified without cost. Failure on the part of the Plaintiff to file such receipt in Court shall be grounds for dismissal of the action. During the pendency and hearing of any and all Judicial proceedings incident to such disciplinary action the sanctions imposed upon the accused by the Department shall remain in full force and effect.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Order of revocation or suspension as prima facie evidence.] § 17.09* An order of revocation, suspension, placing the license on probationary status, or other formal disciplinary action as the Department may deem proper, or a certified copy thereof, over the seal of the Department and purporting to be signed by the Director, is prima facie proof that:

1. Such signature is the genuine signature of the Director;
2. The Director is duly appointed and qualified; and
3. The Board and the members thereof are qualified.



Such proof may be rebutted.  
*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

**Action and report of board—Reasons of disagreement by Director—Necessity for exercise of powers—Re-examination or re-hearing.] § 17.10.**

None of the disciplinary functions, powers and duties enumerated in this Act shall be exercised by the Department except upon the action and report in writing of the Board.

In all instances, under this Act, in which the Board has rendered a recommendation to the Director with respect to a particular physician, the Director shall, in the event that he disagrees with or takes action contrary to the recommendation of the Board, file with the Board and the Secretary of State his specific written reasons of disagreement with the Board. Such reasons shall be filed within 30 days of the occurrence of the Director's contrary position having been taken.

The action and report in writing of a majority of the Board designated is sufficient authority upon which the Director may act.

Whenever the Director is satisfied that substantial justice has not been done either in an examination, or in a formal disciplinary action, or refusal to restore a license or certificate, he may order a re-examination or re-hearing by the same or other examiners.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

**Confidentiality of information received at hearings.] § 17.11** In all hearings conducted under this Act, information received, pursuant to law, relating to any information acquired by a physician in attending any patient in a professional character, necessary to enable him professionally to serve such patient, shall be deemed strictly confidential and shall only be made available either as part of the record of such hearing or otherwise; (1) when such record is required, in its entirety, for purposes of judicial review pursuant to this Act; or (2) upon the express, written consent of the patient, or in the case of his death or disability, of his personal representative.

*Added by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

**Liability for disciplinary action without reasonable basis in fact.] § 17.12** In the event that the Department's order of revocation, suspension, placing the licensee on probationary status, or other order of formal disciplinary action is without any reasonable basis in fact of any kind, then the State of Illinois shall be liable to the injured physician for those special damages he has suffered as a direct result of such order.

*Added by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

**Report of violations—Immunity from liability—Assistance in medical competency examinations—Hearing officers.] § 17.13** Any physician licensed under this Act, the Illinois State Medical Society, the Illinois Osteopathic Association, the Chiropractic Association, or any component societies of any of these three groups, and any other person, may report to the Board any information such physician, association, society, or person may have which appears to show that a physician is or may be in violation of any of the provisions of Section 16 of the Medical Practice Act. Any such physician, association, society or person, participating in good faith in the making of a report, under this Act, shall have immunity from any liability, civil, criminal, or that otherwise might result by reason of such actions. For the purpose of any proceedings, civil or criminal, the good faith of any such physician, association, society or persons shall be presumed. The Board may request the Illinois State Medical Society, the Illinois Osteopathic Association,

or the Illinois Chiropractic Association both to assist the Board in preparing for or conducting any medical competency examination as the Board may deem appropriate. The Board shall retain and use such hearing officers as it deems necessary.

*Amended by P.A. 80-965, § 1, eff. Sept. 22, 1977.*

**Punishment for doing certain acts without license.] § 24.** If any person holds himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings; or suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment of any person with the intention of receiving therefore, either directly or indirectly, any fee, gift, or compensation whatsoever; or diagnoses or attempts to diagnose, operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment, of another; or maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment; or attaches the title Doctor, Physician, Surgeon, M.D. or any other word or abbreviation to his name, indicating that he is engaged in the treatment of human ailments as a business; and does not possess a valid license issued by the authority of this State to practice the treatment of human ailments in any manner, he shall be sentenced as provided in Section 35.1.

*Amended by P.A. 77-2708, § 1, eff. Jan. 1, 1973.*

## Physician's Assistants Practice Act

**Section 1.** The purpose and legislative intent of this Act is to encourage and promote the more effective utilization of the skills of physicians by enabling them to delegate certain health tasks to physician's assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.

**Section 2.** This Act shall be known and may be cited as the "Physician's Assistants Practice Act."

**Section 3.** "Physician's assistant" means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act". A physician's assistant may perform such medical procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the direct supervision of a physician. Physician's assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physician's assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act.

*Amended by P.A. 81-1109, § 1, eff. Jan. 1, 1980.*

**Section 4.** No physician's assistant shall use the title of doctor or associate with his name any other term which would indicate to other persons that he is qualified to engage in the general practice of medicine. A physician's assistant shall not be allowed to bill patients or in any way to charge for services. Nothing in this Act, however, shall be so construed as to prevent the employer of a



physician's assistant from charging for services rendered by the physician's assistant. The supervising physician shall file with the Department notice of employment discharge or supervisory control of a physician's assistant at the time of employment, discharge or assumption of supervisory control of an assistant.

*Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 5.** No more than one physician's assistant shall be employed by a physician. Physician's assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and engaged in private clinical practice, or in clinical practice in public health or other community health facilities. Physician's assistants may be employed by the Department of Corrections, or the Department of Mental Health and Developmental Disabilities for service in facilities maintained by such Departments and affiliated training facilities in programs conducted under the authority of the Director of Corrections or the Director of the Department of Mental Health and Developmental Disabilities. Each physician's assistant employed by the Department of Corrections or the Department of Mental Health and Developmental Disabilities shall be under the direct supervision of a fully licensed physician employed by such Departments who is engaged in the full-time clinical practice of medicine in direct patient care. Duties of each physician's assistant employed by such Departments are limited to those within the scope of practice of the supervising physician who is fully responsible for all physician assistant's activities. No physician shall be allowed to supervise more than one physician's assistant.

*Amended by P.A. 81-665, § 1, Jan. 1, 1980.*

**Section 5a.** Notwithstanding any other provision of this Act, physician's assistants may be employed by jail or prison health facilities under the jurisdiction of the "County Hospitals Governing Commission Act", approved April 25, 1969, as now or hereafter amended. Each jail or prison health facility shall prepare written guidelines and procedures approved by the governing body provided that said guidelines and procedures are not in conflict with the rules and regulations of the Illinois Department of Registration and Education adopted pursuant to the Physician's Assistant Act as now or hereafter amended. The employing health facility shall be legally responsible for the care and treatment of persons attended by the physician's assistants.

*Added by P.A. 81-1109, § 1, eff. Jan. 1, 1980.*

**Section 6.** Each applicant for a physician's assistant certificate shall:

1. Hold a currently valid National Commission on Certification of Physician's Assistants certificate as provided in Section 9.

2. Submit evidence under oath satisfactory to the Department that:

- (a) He is 21 years of age or over;
- (b) He is of good moral character;
- (c) He has the preliminary and professional education required by this Act;
- (d) He is free of contagious diseases.

3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.

4. Pay to the Department of Registration and Education at the time of application, a certification fee of \$25. The fee for subsequent renewal of a certificate without lapse shall be \$15.

*Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 7.** Except as otherwise provided in this Act, the minimum standards of educational requirements prior to

certification shall consist of the following:

(a) Successful completion of a 4 year course of instruction in a high school, or its equivalent, as determined by the examining committee; and

(b) Successful completion of a specialized course for physician's assistants approved by the Committee on Allied Health Education and Accreditation of the American Medical Association's Council on Medical Education and the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training or the requirements set forth by the National Commission on Certification of Physician's Assistants.

*Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 9.** Subject to the provision of this Act, the Department of Registration and Education shall:

1. Promulgate rules approved by the examining committee setting forth standards to be met by a school or institution offering a course of training for physician's assistants prior to approval of such school or institution.

2. Promulgate rules approved by the examining committee setting forth uniform and reasonable standards of instruction, including but not limited to specific subjects taught, to be met prior to approval of such course of instruction for physician's assistants.

3. Determine the reputability and good standing of such schools or institutions and their course of instruction for physician's assistants by reference to compliance with such rules, provided that no school of physician's assistants that refuses admittance to applicants solely on account of race, color, sex, or creed shall be considered reputable and in good standing.

4. Prescribe rules for examining candidates for a certificate as physician's assistant.

5. All examinations provided for by this Act shall be conducted under rules and regulations prescribed by the Department of Registration and Education.

No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act", approved June 15, 1951, as amended.

*Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 10.** Upon the satisfactory completion of application and examination procedures and compliance with the applicable rules and regulations of the Department of Registration and Education, the Department shall issue a physician's assistant certificate to the qualifying applicant who currently holds a valid certificate issued by the national Commission on Certification of Physician's Assistants. Those individuals who have made application to sit for the national examination may function as physician's assistants for a period not to exceed 15 months following graduation, provided they are eligible for the next examination's administration. Such authorization shall not be renewable.

*Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 11.** The Illinois State Medical Disciplinary Board may revoke or withdraw the certificate issued under this Act upon any of the following grounds:

1. Conviction in this or another state of any crime which is a felony under the laws of this State, or conviction of a felony in a federal court;

2. Gross malpractice resulting in permanent injury or death of a patient;

3. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

4. Habitual intemperance in the use of alcohol, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties;

5. Employment of fraud, deception or any unlawful means in applying for or securing a certificate as a physician's assistant;

6. Exceeding the authority delegated to him by his employing physician;

7. A violation of any provisions of this Act or of the rules and regulations formulated for its administration. *Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 12.** No action of a disciplinary nature which is predicated on charges alleging unethical or unprofessional conduct of a person who practices as a physician's assistant and which can be reasonably expected to affect adversely that person's maintenance of his present, or his securing of future, employment as such a physician's assistant may be taken by the Department of Registration and Education, by any association, or by any person unless the physician's assistant against whom such charges are made is afforded the right to be represented by legal counsel of his choosing and to present any witness, whether an attorney or otherwise, to testify on matters relevant to such charges.

**Section 13.** Certificates may be revoked or suspended only in the manner provided by Section 60b through 60h inclusive of "The Civil Administrative Code of Illinois," approved March 7, 1917, as now or hereafter amended.

**Section 14.** All final administrative decisions of the Department of Registration and Education are subject to

judicial review pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined in Section 1 of the "Administrative Review Act."

**Section 15.** All certificates issued under this Act must be renewed every 2 years after their issuance and the examining committee may require a physician's assistant to complete additional courses of medical instruction as a prerequisite to renewal of certification, and may require a physician's assistant to submit to a mental or physical examination at any time felt necessary by the examining committee. Renewal of such certificates shall be contingent upon the individual's continuing to fulfill all of the requirements for issuance of a certificate under this Act. *Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 16.** No person shall use the title or perform the duties of "physician's assistant" unless he is a qualified holder of a certificate as provided in this Act. A certified physician's assistant shall wear on his person a visible identification indicating that he is certified as a physician's assistant while acting in the course of his duties.

**Section 17.** The Medical Examining Committee of the Department of Registration and Education shall review the provisions of this Act to determine its effectiveness and accomplishments and shall solicit the cooperation and advice of certified physician's assistants. The Committee shall report its findings and recommendations to the Governor and the General Assembly on January 1, 1980.

*Amended by P.A. 80-811, § 1, eff. Sept. 20, 1977.*

**Section 18.** This Act takes effect July 1, 1976.

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## DEPARTMENT OF REHABILITATION SERVICES

623 East Adams Street  
Springfield, IL 62705  
James S. Jeffers, *Director*

The Department of Rehabilitation Services is a statutory agency which determines medical eligibility for applicants for cash benefits under Social Security Disability Insurance, Supplemental Security Income, provides rehabilitation services and operates residential/educational/rehabilitation facilities for disabled adults and children of or near public school age who cannot be appropriately served by community resources. Clients who have a vocational goal are provided appropriate quality rehabil-

itation services including evaluation, education, training, guidance, counseling, job placement and other medical and support services. For eligible persons, the Department provides Home Services to severely disabled persons under the age of 60 who do not have a vocational goal but who are at risk of being institutionalized on a long-term basis. All services are provided directly or indirectly by the Department.



## DEPARTMENT OF CORRECTIONS

160 N. LaSalle  
Chicago, IL 60601  
(312) 793-2955  
1301 Concordia Court  
Springfield, IL 62702  
(217) 522-2666  
Gayle M. Franzen, *Director*

Michael P. Lane, Assistant Director-Adult Division  
William O. Gillespie, Assistant Director-Juvenile Division  
Laura Jibben, Executive Assistant to the Director  
Anthony M. Scillia, Deputy Director-Community Services Division  
Jerry Stepaniak, Deputy Director-Management Services Division  
Dr. William Craine, Deputy Director-Program Services Division  
A. M. Monahan, Deputy Director-Operations Division  
Laurel Rans, Deputy Director-Policy Development Division  
Samuel J. Sublett, Accreditation Manager  
Melody McDowell, Public Information Officer  
Marie Hall, Medical Services Administrator

*Programs:* 1) To develop and maintain reception and evaluation units for the purpose of analyzing the custody and rehabilitation needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, rehabilitation and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to co-operate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the State.

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## Medical Legal Information

*The purpose of this section is to present to the Illinois medical community a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations. It should not be construed as presenting legal opinion, rather general considerations. Information is intended to be illustrative only and does not establish nor imply a standard of care.*

### ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a corporate counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries, through the Board of Trustees, made by the component county medical societies when they are of general interest to the medical community. Although the Illinois State Medical

Society does not provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice. For personal legal services, members are encouraged to retain an attorney.

## THE PHYSICIAN-PATIENT RELATIONSHIP

### Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be agreed between the physician and the patient. Whenever possible, the physician should discuss his fee with the patient in advance of treatment.

While the physician/patient relationship is mutually elective, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;

2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract. In any such instance, personal counsel should be consulted.

When the physician has a reasonable basis to terminate his care of the patient, he must provide the patient with sufficient, reasonable written notice of his intention to withdraw so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured. Upon request, the physician should make copies of his records of the care he rendered to the patient available to a new physician selected by the patient.

### PATIENT RECORDS

Illinois law provides that hospitals in the state shall, upon the written demand of any discharged patient, permit that patient, the patient's physician or authorized attorney to examine and make copies of his medical records. These disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship, except as provided by the Illinois Mental Health Code. With respect to the physician's office records, the statute was amended in 1976 to provide that every physician shall, upon the demand of any patient who has been treated by him, permit the patient's attorney or physician who is currently treating him to examine and copy all medical records in

connection with the treatment of the patient. Psychiatric records are excluded, except when ordered by a Court and as provided by the Illinois Mental Health Code. The physician to whom the request is directed must respond within a reasonable time and shall be reimbursed by the patient or his representative for all reasonable costs resulting from examining or duplicating the physician's records.

Physicians should be cognizant of legal requirements for confidentiality of alcohol and drug abuse patient records.

### NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill can result in liability if the patient is thereby injured.

In recent years, in part through the adoption of new laws, but primarily through court decisions, professional liability has been significantly expanded. A recent ruling of the Illinois Supreme Court, for example, extended liability in a certain circumstance for birth defects suffered by a child as a consequence of an injury its mother suffered eight years before the child was conceived. The Court reasoned that the defendant hospital and doctor should have known that the harm caused the mother could have resulted in injury to the child born many years later. This case establishes a "chain of accountability" which dramatically increases exposure to liability and underscores the fact that the problems associated with medical malpractice continue to jeopardize the delivery of quality medical care.

The physician is liable for his own negligent acts and the negligent acts of all employees subject to his control or supervision while acting within the scope of their employment. In the case of a partnership, he also may be liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. However, insurance coverage is not a panacea for expanded liability. Each physician must undertake affirmative efforts to reduce the risks associated with the rendering of health care services.

The American Medical Association published a pamphlet entitled "Professional Liability and the Physician."

Twenty guidelines for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.
2. The physician must know and exercise his legal duty to the patient.
3. The physician must avoid destructive and unethical criticism of the work of other physicians.
4. The physician must keep records which clearly show what was done and when it was done and which demonstrate that the care given met fully the standards of good care as practiced in the community or in similar communities. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.
5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.
6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.
7. The physician must refrain from over-optimistic prognoses.
8. The physician must advise his patients of any intended absences from practice and recommend, or make



available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure a consent, in writing, for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a complete explanation of the procedure and its risks and possible complications. He must also first obtain a signed consent from the patient and from the patient's spouse, if the patient is married. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may be performed lawfully with the consent of the patient and preferably with the consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician

should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing a diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In addition to these general guidelines to good medical practice, the physician should keep current and be in compliance with hospital regulations and standards enforced by governmental agencies, the Joint Commission on Accreditation of Hospitals, and the bylaws of his hospital and its medical staff. The physician has the responsibility to maintain good records of his care of his patients, to recommend consultation when the advice of a specialist is indicated, and to keep his patients informed of the progress of their care. The physician, as a member of an organized hospital medical staff, also has the duty to participate in, and submit to, peer review for purposes of monitoring his professional credentials and performance and for evaluating the quality and appropriateness of the patient care he delivers.

## LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who in good faith provide emergency care without fee to a person, shall not, as a result of acts or omissions, except willful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any

physician, serving on any medical audit or peer review committee shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve willful or wanton misconduct.

## ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who prescribe or dispense various controlled substances are required to register with the Illinois Department of Registration and Education. Physicians who dispense "designated products," must comply with state law requiring the triplicate prescription form, whereby the dispensing physician must submit copies of the triplicate

prescription to the Illinois Department of Registration and Education in the same manner as a pharmacist fulfilling that prescription. Categories of drugs under which registration is required are almost identical to those established by the Federal DEA. Registration must be renewed annually.

## AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or
3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the

right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by

whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization," provided for above,

means any printed, typed or handwritten communication signed by the person granting the authorization.

In order to avoid the possibility of liability, autopsies should only be performed when ordered by the coroner or upon the appropriate written consent of the next of kin as specified above. (The coroner may order an autopsy directly against the wishes of the next of kin). Cooperation should be forthcoming in cases under the coroner's jurisdiction.

## CONSENT OF MINORS TO MEDICAL TREATMENT

**1. Situations Where Consent Need Not Be Obtained For Treatment of a Minor:** Where a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health.

**2. Parental Consent for Treatment of a Minor Child When Parent is Also a Minor:** Illinois law provides that any parent, including a parent who is a minor, may consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority, and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor, or a person age 18 or older, is not voidable because of such minority and Illinois law further provides that for such purpose, such married person, who is a minor, or such pregnant woman, who is a minor, or a person age 18 or older, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person who has attained majority (age 18 or older).

**3. Birth Control Services for Minors:** Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor who meets any of the following criteria: is married; is a parent; is pregnant; has the consent of parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or is referred for such services by a physician, clergyman or a planned parenthood agency.

**4. Venereal Disease, Drug Use and Alcholemla—Consent to Treatment By Minor:** Notwithstanding any other provision of law, a minor 12 years of age or older who may have come into contact with any venereal disease or suffers from the use of depressant or stimulant drugs, as defined in the Drug Abuse Control Act, or narcotic drugs, as defined in the Uniform Narcotic Drug Act, or may be determined to be an alcoholic or an intoxicated person, as defined in the Alcoholism and Intoxication Treatment Act, may give consent to the furnishing of medical care or counseling related to the

diagnosis or treatment of such disease. Each incident of such venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with regulations adopted pursuant to statute or ordinance. The consent of the parent, parents, or legal guardian of such minor shall not be necessary to authorize medical care or counseling related to the diagnosis or treatment of such disease or drug or narcotic use or alcohol consumption. The consent of the minor shall be valid and binding as if the minor had achieved his or her majority. Such consent shall not be voidable, nor subject to later disaffirmance, because of minority.

Anyone involved in the furnishing of medical care or counseling related to the diagnosis or treatment of such minor's disease or drug, narcotic or alcohol use shall, upon the minor's consent, make reasonable efforts, to involve the family of such minor in his or her treatment, if the person furnishing such treatment believes that the involvement of the family will not be detrimental to the progress and care of such minor. Reasonable effort shall be extended to assist the minor in accepting the involvement of his or her family in the care and treatment being given.

**5. Notification of Parents of Minor Treated for Alcohol Abuse:** However in any instance in which a minor above the age of 12 years is being treated for alcohol use the person furnishing such treatment shall notify the parent or guardian of such minor following the second treatment of such alcohol use unless in that person's professional judgment such notification would jeopardize the course of treatment being pursued. In no case, however, shall a period of more than three months elapse without the parent or guardian of said minor being notified of the treatment afforded.

**6. Notification of Parents of Minor Treated for Venereal Disease or Chemical Abuse:** Any physician who provides diagnosis or treatment or any licensed clinical psychologist or professionally trained social worker with a master's degree or any addiction aid or addiction specialist employed by the Dangerous Drugs Commission or by units of local government or by agencies or organizations operating drug abuse programs funded or licensed by the Federal Government or the State of Illinois or any qualified person employed by or associated with any public or private alcoholism program licensed by the State of Illinois who provides counseling to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic or from alcohol consumption referred to in the section immediately preceding may, but shall not be obligated to, inform the parent, parents, or guardian of any such minor as to the treatment given or needed.



## UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law mandates coverage by physicians who employ only one person. If physicians have specific questions regarding the applicability of unemployment compensation to their

employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

## BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by

transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

- a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and
- b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

## IMMUNIZATION

In 1973, the Illinois General Assembly eliminated a listing of specific diseases against which there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations,

which may change from time to time, as to those diseases against which children will be immunized. This affects the School Code and the Communicable Disease Act. A comprehensive treatment of immunization requirements is included in the September, 1980, *IMJ*.

## MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. A primary reason for forbidding the use of the corporate form for doctors was that the personal assets of the officers, directors and stockholders are generally beyond the reach of creditors, including persons who acquire a legal claim against the corporation after suffering injury resulting from the actions of the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability by the use of a "corporate shield." However, the corporation can be sued as the employer and the individual doctor-employee can also be sued.

The corporate form does, however, present certain ad-

vantages, particularly in the area of taxation. There has never been a compelling reason to deny these benefits to doctors and other professionals.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. In the case of a professional services corporation also authorized under current Illinois law, the secretary of the corporation need not be a physician.

The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate, in addition to the requirements of filing with the office of the Secretary of State. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

## MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Health Facilities Planning Board.

A provision in the original legislation which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition. At the federal level, renewed efforts are underway to bring all outpatient facilities, including the doctor's office, under the provisions of the law.

This law covers construction or modification plans involving an expenditure of more than \$150,000, or a substantial change in services or bed capacity.

Under Public Law 93-641, local Health Services Agencies are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state Health Planning Board for final action.

The state agency is required to study: (1) area size;

(2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities; (5) availability of alternative facilities and services; and, (6) availability of necessary personnel.

Undoubtedly, the role of health planning agencies will expand and the physician will feel the effects and influence of regulations promulgated by these organizations. While the private practice of medicine is as yet relatively "free" of the jurisdiction of these agencies, the decisions of the Board are already reaching out to limit the purchase of new equipment and the development of new services by hospitals and other institutions in which the doctor performs many of his professional services. It is reasonable to expect that with the current government emphases on cost containment in health care, the physician's practice can and will be affected. Therefore, it is in each physician's best interest to monitor these developments closely in the months and years ahead.

## CURRENT DEVELOPMENTS IN HEALTH LAW

The current health scene is shaped, at least in part, by the adoption of a multiplicity of new laws and regulations, by court decisions and by the methods employed by the many agencies functioning at all levels of government. For example, the Federal Trade Commission continues its aggressive investigations of the health field, even though a Supreme Court decision diluted their efforts to eliminate the use of a Relative Value Scale in setting fees for anesthesiologists.

Unfortunately, litigation based in medical malpractice is increasing once again, stimulated by recent court decisions which expand liability for doctors and hospitals. One set of decisions by the Illinois Supreme Court gave new impetus to the practice of apportioning "fault" among joint-tortfeasors. It heightened the prospect of hospitals and doctors suing each other in third party lawsuits in order to distribute the responsibility for settlements and judgments arising out of negligence law-

suits based on the degree of liability attributed to each named co-defendant. The added stress and costs will not be absorbed easily by the health field. Another recent Illinois Supreme Court decision ruled that radiation (used in therapy) is a product, not a professional service, and, as such, shall be governed by the legal doctrine of *strict* liability. This decision places a higher standard of care on doctors and hospitals in the circumstances surrounding the administration of radiation therapy. There will exist a kind of "presumption" of negligence in any case resulting in an injury to a patient who has received radiation.

In response to these and earlier developments in the field of health law, the Illinois State Medical Society, through its Board of Trustees, addresses specific issues and attempts to take action to obviate or minimize negative impact on physicians or the profession.

## ILLINOIS LAW

In a complex, technology-oriented society, with an ever-increasing degree of sophistication among consumers, and a burgeoning bureaucracy, laws and regulations have been put into place to protect the public good. While restrictive laws are regarded as impositions by some, they are a fact of life. Some laws, of course, are viewed differently by different people. And some laws are considered by some to be unjust, discriminatory, or inequitable. Generally, however, most people recognize the need to have an orderly system under which the affairs of society are conducted.

With respect to the practice of medicine, many sections of the statutes refer to items controlling or describing activities of a physician. Others limit the public. Further references govern various health care situations in society. All physicians are impacted upon by the statutes, and by the Rules and Regulations, if any, implementing them. It is important that there be knowledge of these laws. It is just as important that physicians have a personal attorney to assist in assuring compliance with the statutes.

By reference to the volumes codifying Illinois law, one can

generally identify if any particular statute applies to oneself in a given situation. To help ISMS members find these, the three volumes of *Illinois Revised Statutes* (1979) have been researched. While it would be impossible to reprint all pertinent parts of the laws, an index has been developed. This sets forth the chapter and statute section, and the title of the Act or section. Using this and referencing the statutes (available in all libraries, attorneys' offices, as well as other locations), one can read what the law says on the subject contained therein.

Rather than attempting to lump the statutes into subject groupings, a straight run through has been accomplished. Groupings would result in duplication and possible misinterpretations. While the listing is as complete as possible, it is possible that some items could have been overlooked. Notification of omission, to *IMJ*, would be appreciated. No interpretation is intended or implied; every physician should consult an attorney to determine application to individual situations.



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This tabulation refers only to general sections of the statutes, in most instances. For reference to more specific items, one could consult the Index to the Statutes (Volume 4).

# Joint Commission on Accreditation of Hospitals 1981 Medical Staff Standards

## Principle

*There shall be a single organized medical staff that has the overall responsibility for the quality of all medical care provided to patients, and for the ethical conduct and professional practices of its members, as well as for accounting therefor to the governing body.*

**Standard I:** The medical staff shall assure that each member is qualified for membership, and shall strive to maintain the optimal level of professional performance of its members through the appointment/reappointment procedure, the specific delineation of clinical privileges, and the periodic in-depth reappraisal of each staff member. (*Interpretative information accompanying this standard details provisions for qualifications, method of selection, privilege delineation and staff reappointment/reappraisal.*)

**Standard II:** The medical staff shall be organized to accomplish its required functions. (*Interpretative information accompanying this standard details provisions for medical staff categorization, e.g., active, associate, courtesy, consulting, and honorary staff; provisional and temporary status, medical staff officers, executive committee and departments.*)

**Standard III:** The medical staff shall develop and adopt bylaws, rules and regulations to establish a framework of self-government and a

means of accountability to the governing body.

**Standard IV:** The medical staff shall provide mechanisms for the regular review, evaluation, and monitoring of medical staff practice and functions. Such mechanisms shall be designed to maintain high professional standards of care. (*Interpretative information accompanying this standard details provisions for tissue review, pharmacy and therapeutics and medical record functions, blood utilization and antibiotic usage review and other staff functions.*)

**Standard V:** The medical staff shall participate in a program of continuing education.

The Joint Commission on Accreditation of Hospitals recently revised the Accreditation Manual for Hospitals. A copy of the revised manual has been sent to each accredited Illinois hospital. The medical staff standards are given extensive interpretation, which is not included herein, but should be obtained from the revised manual for a full understanding. The new manual also includes extensive revisions in several other sections, which impact on medical staff activities, and should be examined.

In significant part, this section is reprinted by permission from the "JCAH Accreditation Manual for Hospitals," 1981 edition, pages 93-109.

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## ***Legislature Adjourns— Final Results A Question Mark***

Someone once said that if reincarnation were possible, he would want to come back as a bill in the General Assembly. The reason? No matter what the subject, no matter what the specifics, no matter how soundly defeated, legislation considered by the General Assembly seems to have the remarkable ability to keep coming back to life—in many cases more times than could a cat. A few examples might explain this phenomenon.

**H.B. 746** (Bianco, R-Chicago) mandates podiatric coverage in all Blue Cross/Blue Shield policies sold in Illinois. This bill has been introduced in every General Assembly at least once for at least the last 6 years—it has similarly been defeated at least once every year for the last 6 years as well. In 1980, it finally passed over strong ISMS opposition. This year strategists supporting the bill called for a vote shortly before the 1979 session ended and, when the bill was defeated, used a parliamentary maneuver called “postponed consideration” to keep the bill technically alive. The significant aspect of this tactic is that it gave those supporters an accurate list of the members of the General Assembly who opposed the bill and it gave those same supporters a whole year to intensely lobby the four or five legislators it would take to change the results. Under the kind of pressure these legislators received from every podiatrist and every podiatric patient in their districts, it is not difficult to see why some of those legislators, when the bill again came up for a vote in 1980, voted in support.

**H.B. 746** now awaits action by Governor Thompson.

**H.B. 3179** (Brummer, D-Effingham) originally was introduced to allow municipalities and counties to issue revenue bonds to provide medical or dental offices or clinics. It passed the House in this form, but when it got to the Senate, it was amended by striking every word of the bill and substituting language creating the ambulance district law. Because the bill passed the Senate in a different form than it had passed the House, **H.B. 3179** went to Conference Committee where it was again changed. The final version of the bill provides for the creation of ambulance districts by public referendum which will allow for the maintenance and operation of safe ambulances within the designated district.

**H.B. 3179** also awaits action by the Governor.

**H.B. 1010** was drafted by the Judiciary II Committee and amended the Corrections Code in relation to the release or discharge of persons

found not guilty of an offense by reason of insanity. The Committee, after lengthy debate and testimony, struck all of the original language and substituted different criteria for the release of such persons. When the bill was debated on the House floor, it was again amended by striking all existing language and substituting a new version which maintained the same criteria but made technical changes to allow the bill to comply with other laws governing this situation. The bill passed in this form, but when it got to the Senate, the Senate Judiciary II Committee further amended the bill by making a variety of non-substantive changes as well as by changing the definition of the term “subject of involuntary admission.” Later the Senate adopted two other amendments, one relating to aggravated kidnapping, which obviously has little to do with the concept of the insanity defense, and the other of which dealt with the use of lethal injections for executions, which had even less to do with the question of the original bill. The House refused to accept the Senate’s amendments and the bill was tabled, which under normal circumstances, kills the bill. Late in the session, however, a motion was filed to take the bill from the table so that the issues involved could again be considered. That motion passed and a Conference Committee was named to work out a compromise bill. As one of the last acts of the 1980 session, the General Assembly adopted the Conference Committee report which returned the bill to the form it was in after it had passed the House, while including the non-substantive changes made by the Senate Judiciary II Committee, and removing all other Senate amendments.

**H.B. 1010**, as finally adopted, now awaits action by the Governor, but there is doubt as to whether he will sign it.

**S.B. 1524** (Sangmeister, D-Joliet) originally was one of a variety of bills which sought to define a viable fetus as a person under the Criminal Code. The intent of the sponsor was to rectify what the sponsor perceived to be a problem which developed when a man shot his pregnant wife, killing both the mother and child, and the local prosecuting attorney could not prosecute him for killing the child because the Criminal Code does not include unborn children at any stage of development. Senator Sangmeister used the term “viable fetus” to mean a human fetus capable of existence independent of the mother including independent existence which is



dependent upon life support equipment. ISMS had serious problems with the bill, in that we believed that a physician performing a legal late-second-trimester abortion could potentially be subject to criminal penalties, based on this definition and the fact that neonatal units have been able to save babies born at 24 weeks. Amendments were added which clearly exempted the physician in this situation, but the whole question of abortion had been raised with both pro- and anti-abortion forces objecting to the term "viable fetus". Late in the session, the bill was amended repeatedly, and just as frequently amendments were defeated or withdrawn. Finally, 5 days before the session ended, the bill was gutted, and replaced with language which mandated that the habitual criminal (the so-called "three time loser") would be sentenced to life imprisonment if the death sentence was not imposed for his third felony conviction.

S.B. 1524, as finally adopted, was signed by the Governor and is now P.A. 81-1270.

S.B. 1747 (Newhouse, D-Chicago) was originally a bill to change the way reimbursement to medical providers is computed by the Department of Public Aid. As first introduced, it would

have directly tied Medicaid reimbursement rates to Medicare reimbursement rates. Later it was amended to remove this direct relationship, but would still have provided some additional compensation to medical providers. When the bill got to the House, proponents of another bill which would have mandated Public Aid coverage for the medical care expenses of pregnant teenagers attempted to have the provisions of this bill added to S.B. 1747. Chaos resulted, and in the following days, the bill was amended to modify the child age eligibility requirement for Aid to Dependent Children, from birth to the time of confirmation of pregnancy, in the case of qualified women. This amendment is seen as trying to assure that first-time pregnancies of public aid recipients are covered under the Public Aid Code.

S.B. 1747 awaits the Governor's action.

Listed below are a few of the many bills of interest to Illinois physicians considered during the past session of the 81st General Assembly. While this list is not all inclusive, we believe it will be helpful to our readers. Anyone desiring further information should contact the ISMS Governmental Affairs Division in the Chicago Office.

<i>BILL #</i>	<i>DESCRIPTION &amp; ISMS POSITION (Underlined)</i>	<i>STATUS AS OF 9/11/80</i>
*HB 625	Chapman/Berman-State Catastrophic Health Insurance; provides for Director of Public Health to make payments on behalf of eligible persons for health expenses which exceed specified limits. Ties physicians fees to IDPA reimbursement levels. <u>Opposed in current form.</u>	Recommitted to Senate Public Health com.
HB 746	Bianco/Egan-Mandates the inclusion of podiatric coverage in all BC/BS policies. <u>Opposed.</u>	Signed by Governor PA 81-1456
*HB 958	White/Lemke-Creates Counselor Registration & Licensure Act; Restricts those who may provide counseling services. <u>Opposed.</u>	In Senate Rules com.
*HB 1011	Sandquist-Mandates direct reimbursement of clinical social workers under mental insurance benefits. <u>Opposed.</u>	Defeated in the House
*HB 1517	Griesheimer/Netsch-Public Smoking Act. Prohibits smoking in designated public areas; penalties for violations. <u>Support concept, oppose penalties.</u>	In Senate Rules com.
HB 2227	Reilly/Schaffer-Creates Emergency Medical Services Systems Act, administered by IDPH; empowers Dept. to license & regulate ambulances. <u>No opposition as amended.</u>	Passed both Houses. To the Governor.
*HB 2528	Kane-Repeals acts providing for public health districts, hospital districts, T.B. sanitarium districts, transfers powers, property and personnel to counties. <u>Opposed.</u>	Defeated in the House.

<i>BILL #</i>	<i>DESCRIPTION &amp; ISMS POSITION (Underlined)</i>	<i>STATUS AS OF 9/11/80</i>
HB 2771	Klosak/Rupp-Changes name of Dept. of R & E to Dept. of Professional & Occupational Regulation. Authorizes Dept. to give tests & collect fees; repeals act creating Division of Professional Supervision. <u>No opposition in current form.</u>	Signed by Governor PA 81-1381
*HB 2793	Catania/McLendon-Requires IDPA to assure no person shall be denied necessary medical care because of financial indigency. <u>No position.</u>	Failed in Senate.
*HB 2960	Simms/Keats-Requires the disclosure of the location of the recipient of a criminal arrest warrant when such person is under the care of a mental health facility—medical records protected. <u>No opposition.</u>	In Senate Rules com.
*HB 2965	Mautino-Amends Illinois Nursing Act; provides special licensure for those practicing nurse midwifery; allows those licensed to prescribe certain drugs and devices. <u>Opposed.</u>	In House Rules com.
*HB 2990	Katz/Savickas-Provides space on drivers license to donate anatomical gifts, requires explanatory information to be included with renewal notices. <u>No opposition.</u>	In Senate Rules com.
HB 2997	Brummer/Bruce-Authorizes organization of not for profit corp. to establish, operate and control a mental health agency offering services to the public & supported in whole or in part by public funds as provided in Community Mental Health Act. <u>No opposition-ISMS amendment added.</u>	Passed both Houses. To the Governor.
*HB 3089	Cullerton-Authorizes disclosure of records and communications in civil and criminal proceedings where the <u>testimonial capacity of a witness may be in issue.</u> <u>Opposed.</u>	In House Rules com.
*HB 3150	Katz-Creates a legal basis for determination of when death has occurred. <u>Opposed in current form.</u>	In House Rules com.
HB 3179	Brummer/Bruce-Amended to create ambulance districts. <u>No opposition.</u>	Passed both Houses. To the Governor.
*HB 3189	Sandquist-Mandates direct reimbursement of clinical social workers under mental insurance benefits; limits physician reimbursement for mental health treatment to psychiatrists. <u>Opposed.</u>	In House Rules com.
*HB 3214	Chapman/Netsch-Formulates health & career assistance programs for adolescent parent support; empowers IDPH for planning; creates task force. <u>No opposition.</u>	In Senate Rules com.
*HB 3215	Satterthwaite-Authorizes IDPH to develop and implement an early pregnancy detection & health care response program tailored to adolescents. <u>No opposition.</u>	Interim Study of House Human Resources com.
*HB 3216	Macdonald/Martin-Authorizes IDPH to develop pilot projects for establishment of service centers that conduct comprehensive programs for adolescent parent support services, including medical services. <u>No opposition as amended.</u>	In Senate Rules com.
*HB 3217	Oblinger/Netsch-Requires consideration of the priority needs of adolescent parents for child day care both by public aid agencies and Dept. of Children. <u>No position.</u>	In Senate Rules com.
*HB 3218	Barnes/Martin-Modifies the child age eligibility requirement for Aid to Dependent Children, from birth to the time of confirmation of pregnancy. <u>Support.</u>	In Senate Rules com.



<i>BILL #</i>	<i>DESCRIPTION &amp; ISMS POSITION (Underlined)</i>	<i>STATUS AS OF 9/11/80</i>
*HB 3219	Braun/Martin-Transfers responsibility for providing services & programs for unwed mother from Dept. of Children to Dept. of Public Health. <u>No opposition.</u>	In Senate Rules com.
*HB 3259	Currie/Newhouse-Requires hospitals to post notice in emergency rooms that emergency medical service will be provided to anyone regardless of payment provisions. <u>No opposition as amended.</u>	In Senate Rules com.
*HB 3314	Daniels/Sangmeister-Amends Criminal Code; includes viable fetus as capable of being murdered. <u>No opposition, ISMS amendment adopted.</u>	Failed in Senate.
*HB 3316	Chapman-Provides for creation of a state plan by IDPH to control human blood & blood components; creates Ill. Blood Council. <u>Opposed.</u>	In House Rules com.
HB 3427	Peters/Schaffer-Removes requirement that director of IDPH be a licensed physician; creates Medical Determination Board consisting of seven physicians. <u>Support.</u>	Signed by Governor. PA 81-1256.
*HB 3458	Grossi/Amends Criminal Code; includes viable fetus as capable of being murdered. <u>No opposition-ISMS amendment adopted.</u>	Tabled
*HB 3466	Jaffe/Lemke-Amends Limitations Act; clarifies applicability of the fraudulent concealment exception to medical malpractice suits. <u>Monitor to protect current statute of limitations.</u>	In Senate Rules com.
*HB 3467	Jaffe/Lemke-Tolls period of limitation in which the insured may bring suit under casualty insurance policies, from date of proof of loss until date of denial of claim. <u>Monitor to protect statute of limitations.</u>	In Senate Rules com.
HB 3485	Macdonald/Geo-Karis-Makes optional coverage available under health insurance plans for reconstructive breast surgery. <u>Support as amended.</u>	Signed by Governor PA 81-1470
*HB 3510	Kent/Knuppel-Exempts facilities owned or operated by Veterans Affairs Dept. from certificate of need law. <u>Support.</u>	On 3rd Reading in the Senate.
*HB 3512	Schisler-Exempts selected physician's assistants from requirement of national certification as condition for state certification. <u>Opposed.</u>	In House Rules com.
*HB 3566	Brummer-Penalizes graduates from public medical schools \$5000 per year upon failure to practice in designated shortage areas. <u>Opposed.</u>	Tabled
*SB 1378	Sommer/Pullen & Catania-Increases Public Aid reimbursements levels for Radiologist services provided on out-patient basis. <u>Support as amended.</u>	Awaits final Senate action
*SB 1453	Jeremiah Joyce-Requires psychotherapists who determine a patient may present danger to a 3rd party to disclose the possibility of danger to the 3rd party. <u>Opposed.</u>	In Senate Rules com.
*SB 1467	D'Arco-Moves valium (diazepam) from Schedule IV to Schedule II, to allow closer monitoring of drug utilization. <u>No opposition.</u>	In Senate Rules com.
*SB 1501	Berning-Creates act relating to regulation of human subjects involved in medical experiments. <u>Opposed.</u>	In Senate Rules com.

<i>BILL #</i>	<i>DESCRIPTION &amp; ISMS POSITION (Underlined)</i>	<i>STATUS AS OF 9/11/80</i>
*SB 1503	DeAngelis-Prohibits giving or receiving campaign contributions aggregating more than \$1500 to or from one source. <u>Opposed.</u>	In Senate Rules com.
SB 1508	Schaffer/Satterthwaite-Amends Alcoholism & Intoxication Treatment Act; substitutes references to Mental Health Code with references to Alcoholism Act & certain federal rules. <u>Support.</u>	Signed by Governor PA 81-1398
SB 1705	Grotberg/Ebbesen-Permits research into effect of cannabis on radiation therapy side-effects. <u>No opposition.</u>	Signed by Governor PA 81-1421
*SB 1732	Wooten-Requires IDPH to license & inspect restaurants. <u>Support limited to House of Delegates action.</u>	In Senate Rules com.
SB 1747	Newhouse/Jane Barnes-Amended to modify the child age eligibility requirement for Aid to Dependent Children, from birth to the time of confirmation of pregnancy. <u>Support.</u> (See HB 3218).	Amendatory Veto 9/11/80
*SB 1758	Jeremiah Joyce-Allows employment of clinical psychologists in management of hospital psychiatric programs. <u>Opposed.</u>	In Senate Rules com.
SB 1815	Grotberg/Oblinger-Requires the IDPH to provide information for facilities providing hospice care. <u>No opposition.</u> ISMS amendment added.	Signed by Governor PA 81-1392
*SB 1834	Berman/Bullock-Allows for licensure by reciprocity of Canadian nurses until June 30, 1983. <u>Support.</u>	In House Rules com.
*SB 1871	Netsch-Amends Pharmacy Practice Act; permits a pharmacist to practice drug product selection unless the physician or other authorized drug prescriber personally indicates substitution is prohibited. <u>Opposed.</u>	In Senate Rules com.
*SB 1874	Netsch-Amends Medical Practice Act; requires dispensing physicians to label drugs; criminal penalty for violation. <u>Opposed in current form.</u>	In Senate Rules com.
SB 1881	Daley/Keane-Amends the Nursing Home Care Reform Act of 1979; allows under specified circumstances admittance into nursing home of patients unable to sign contracts. <u>Support.</u>	Signed by Governor PA 81-1349
SB 1884	Daley/Peters-Requires specimens taken for PKU testing be submitted to IDPH labs; allows licensed medical facility to collect additional samples for testing. Requirement repealed 12/1/83. <u>No opposition.</u>	Signed by Governor PA 81-1415
*SB 1903	D'Arco-Provides for licensing & regulation of those providing electrology services. <u>Opposed.</u>	In Senate Rules com.
*SB 1930	Netsch-Loosens provisions pertaining to disclosure of records and communications of a therapist in criminal proceedings. <u>Opposed.</u>	In Senate Rules com.
*SB 1943	Washington-Provides regulations adopted by IDPA governing the dispensing of health services apply generally to all health providers. <u>Opposed.</u>	In Senate Rules com.
*SB 1958	Netsch-Requires that prescription drugs be labeled with the name of the medicine unless exempted by R & E. <u>Opposed in current form.</u>	In Senate Rules com.

\* THOSE BILLS MARKED BY AN ASTERISK WILL NOT RECEIVE FURTHER CONSIDERATION UNLESS EXTRAORDINARY PARLIAMENTARY MEASURES OCCUR.



# Convention Handbook



## INTERIM MEETING '80

October 25-26

**Continental Regency Hotel  
500 Hamilton Boulevard  
Peoria, Illinois**

Members of the House of Delegates

Delegates and Alternate Delegates to the Illinois State  
Medical Society

Officers of County Medical Societies

Committees of the House of Delegates

ISMS Delegation to the American Medical Association

Schedule of Meetings

Resolutions

*for October, 1980*

# Members of the 1980 House of Delegates

## OFFICERS

President .....	Herschel Browns
President-Elect .....	Fred Z. White
1st Vice President .....	Lawrence L. Hirsch
2nd Vice President .....	George Mitchell
Secretary-Treasurer .....	Eugene P. Johnson
Speaker of the House .....	Robert P. Johnson
Vice Speaker .....	Clifton Reeder

## TRUSTEES

First District .....	John J. Ring	1981	Fourth District .....	George Burke	1982
Second District .....	Allan L. Goslin	1983	Fifth District .....	Robert Prentice	1982
Third District .....	Alfred Clementi	1982	Sixth District .....	Robert R. Hartman	1981
	Audley F. Connor, Jr.	1983	Seventh District .....	Alfred J. Kiessel	1982
	Jere E. Freidheim	1982	Eight District .....	James Laidlaw	1982
	Morris T. Friedell	1981	Ninth District .....	Warren D. Tuttle	1981
	Robert C. Hamilton	1983	Tenth District .....	Julian W. Buser	1981
	Henrietta Herbolzheimer	1981	Eleventh District .....	Kenneth A. Hurst	1983
	Harold J. Lasky	1983	Twelfth District .....	Joseph Perez	1983
	Richard N. Rovner	1983	Trustee-at-Large .....	P. John Seward	
	Joseph Sherrick	1983			
	Cyril C. Wiggishoff	1982			

*Members of the House who have the privilege of the floor without the right to vote in this capacity*

## Past Presidents

J. Ernest Breed* .....	1971	Fredric D. Lake* .....	1975
Edward W. Cannady .....	1970	Burtis E. Montgomery* .....	1966
Newton DuPuy* .....	1968	Caesar Portes* .....	1967
Harlan English* .....	1964	Jacob E. Reisch, Honorary* .....	1979
David S. Fox* .....	1979	Willard C. Scrivner* .....	1974
Edwin S. Hamilton* .....	1962	P. John Seward* .....	1980
H. Close Hesseltine .....	1961	Joseph H. Skom* .....	1977
J. M. Ingalls .....	1976	Leo P. A. Sweeney* .....	1953
C. J. Jannings, III .....	1972	Philip G. Thomsen* .....	1969
Frank J. Jirka, Jr.* .....	1973	George T. Wilkins, Jr. ....	1978

*\*Also a past trustee or councilor*

## Delegates to AMA

Herschel Browns	Theodore Grevas	John J. Ring
Allison Burdick, Jr.	Henrietta Herbolzheimer	Maynard I. Shapiro
Howard C. Burkhead	Lawrence L. Hirsch	Joseph H. Skom
David S. Fox	Morgan M. Meyer	Charles K. Wells
Jack L. Gibbs	Joseph R. O'Donnell	George T. Wilkins, Jr.

## Past Trustees or Councilors

Earl H. Blair .....	Third District	A. Edward Livingston .....	Fifth District
Walter C. Bornemeier .....	Third District	Paul F. Mahon .....	Fifth District
Raymond DesRosiers .....	Third District	Joseph R. O'Donnell .....	Eleventh District
Herbert Dexheimer .....	Tenth District	Mather Pfeiffenberger .....	Sixth District
Alfred Faber .....	Third District	Ralph N. Redmond .....	Second District
Robert T. Fox .....	Third District	Jacob E. Reisch .....	Fifth District
George E. Giffin .....	Second District	George Shropshear .....	Third District
Arthur F. Goodyear .....	Seventh District	Darrell H. Trumpe .....	Fifth District
Lee N. Hamm .....	Fifth District	Frederick E. Weiss .....	Third District
Lawrence L. Hirsch .....	Third District	Charles K. Wells .....	Ninth District
Eugene Hoban .....	Third District	Fred Z. White .....	Fourth District
Ross Hutchison .....	Eleventh District	Herman Wing .....	Third District
Eugene P. Johnson .....	Eighth District	Warren Young .....	Third District
Ted LeBoy .....	Third District	Paul P. Youngberg .....	Fourth District
William M. Lees .....	Third District		



# Delegates and Alternate Delegates to the Illinois State Medical Society

## DOWNSTATE DELEGATES

County	Delegates	Alternates	County	Delegates	Alternates
ADAMS	Walter Stevenson, III	Marvin Grote	MACOUPIN	Robert G. England	Frederico Macaraeg
ALEXANDER	Gemo Y. Wong	Charles L. Yarbrough	MADISON (3)	E. K. DuVivier	Edward Ragsdale
BOND	Boyd McCracken, Sr.	M. K. Kaufman		Melvin Freedman	Robert Hill
BOONE	M. J. Carlisle	Kent Hess		Robert Hamilton	Rosalyn Lepley
BUREAU	James L. Foresman	Louis Lukancic	MARION	Richard Rudman	E. F. Stephens, III
CARROLL	Ronald Miller	C. G. Piper	MARSHALL- PUTNAM	Merle Swearingen	
CASS-BROWN			MASON	Jack Means	
CHAMPAIGN (3)	Arthur R. Traugott	Harold Kolb	MASSAC	Enrique T. Yap	Benito Bajuyo
	Richard Helfrich	Michael Russo	MCDONOUGH	Jack L. McPherson	Lyle E. Adams
	Frank Kresca	Harlan Failor	MCHEMRY	August M. Rossetti	William Larsen
CHRISTIAN	M. T. Salaymeh	Edward D. Slifer	MCLEAN (2)	Loren Boon	Wil Thielemann
CLARK	George T. Mitchell	Eugene P. Johnson		Robert Reardon	Robert E. Knight
CLAY			MENARD		
CLINTON	Wilson L. DuComb	Jose R. Sosa	MERCER	Dennis Palmer	Monty P. McClellan
COLES-			MONROE	Russell W. Jost	E. F. Maglasang
CUMBERLAND	Mack W. Hollowell	Joseph Mallory	MONTGOMERY	Lee Johnson	
CRAWFORD	Charles Salesman	Dean J. Pelley	MORGAN-SCOTT	Frank Norbury	Charles S. Wilson
DEKALB	John W. Ovitiz, Jr.	Dean Miller	MOULTRIE	Eugene J. Boros	Fred Yamamoto
DEWITT	S. Kolandaivelu	Robert E. Myers	OGLE	Don E. Hinderliter	Vincenzo Traina
DOUGLAS	Walter Steiner	Humberto Mondul	PEORIA (5)	Ernest F. Adams	John J. Taraska
DUPAGE (9)	Morgan M. Meyer	Orren D. Baab		Raymond Schendl	Carl Neuhooff
	James P. Campbell	Robert D. Dooley		Dennis Garwacki	Thomas Cusack
	Joseph P. McKay	Raymond A. Dieter		Lorris Bowers	Donald McRaven
	William C. Perkins	James Dunphy		Gene O. Hoerr	William H. Marshall
	William B. Frymark	Garth Smith		C. E. Cawvey	B. A. Kinsman
	Joseph R. O'Donnell	Leo Roberts	PERRY	Wm. E. Mundt	George G. Green
	Thomas W. Stach	Robert Fitzgerald	PIATT	Thomas C. Bunting	Carlos B. Lara
	Ronald M. Severino	Erlo Roth	PIKE	A. L. Robinson	
	Vernon Bartley	Harold Walgren	PULASKI	O. W. Pfisterer	Allan Liefer
	J. M. Ingalls	Duane Haskell	RANDOLPH	Chas. A. DeKovesey	Michael E. Murray
EDGAR			RICHLAND	James F. Duesman	Manuel O. Guerrero
EDWARDS			ROCK ISLAND (3)	Paul Moen	Joseph Leinfelder
EFFINGHAM				Richard Snodgrass	Robert Lelonek
FAYETTE	Joshua Weiner	Hans Rollinger	ST. CLAIR (3)	Ronald Welch	Terrence G. Klingele
FORD	Ross Hutchison	Somchai Supawanich		Thomas P. Meirink	Charles C. Weiland
FRANKLIN	James Durham			Michael G. Murphy	Charles Frazer, Jr.
FULTON	Jack Gibbs	Rod Maguire			
GALLATIN	John E. Doyle		SALINE-POPE-	A. Z. Goldstein	Larry Jones
GREENE	Jose Parcon	Ludwig Dech	HARDIN	Twofig M. Arjmand	John Dietrich
HANCOCK	C. F. Eddingfield	James Coeur	SANGAMON (5)	Edward G. Ference	Robert B. Dodd
HENDERSON	Silvino C. Lindo			John Holland	Stefan Kozak
HENRY-STARK	Richard M. Terry	Reinert Svendsen		Michael Snyder	John C. Young
IROQUOIS	R. K. Swedlund	J. E. Dailey		Elvin Zook	Marion Panepinto
JACKSON	Paul P. Lorenz	Eli L. Borkon	SCHUYLER	Robert E. Cox	Henry C. Zingher
JASPER	Monico Low	Juan Serra	SHELBY	Theodore Little	Edwin J. Siroy
JEFFERSON-			STEPHENSON	William H. Isham	F. H. Des Courouez
HAMILTON	James R. Heersma	H. Goff Thompson	TAZEWELL	Robert M. Wright	Robert L. Tucker
JERSEY-			UNION	Thomas Davis	Wm. Whiting
CALHOUN	Bernard Baalman		VERMILION	Grover W. Seitzinger	W. F. Hensold
JO DAVIESS	Francis Waites	Delbert Williams	WABASH	E. Lowenstein	
KANE (4)	A. Beaumont Johnson	James C. Pritchard	WARREN	K. E. Ambrose	W. Roller
	Wayne Leimbach	William Sheehy	WASHINGTON	Thomas J. Coy	
	James A. McDonald	Kenneth Albrecht	WAYNE	C. J. Jannings, III.	A. R. Marks
	George Shimkus	Robert Flanigan	WHITE	Phillip Boren	
KANKAKEE	Donald Parkhurst	Richard Stoval	WHITESIDE	John Hubbard	
KENDALL	Walter H. Brill	Michael R. Saxon	WILL-GRUNDY		
KNOX	Jerry Ramunis	Juan Espejo	(3)		
LAKE (6)	Arthur A. Woloshin	Richard K. Hawkins		Merle L. Otto	Kenneth M. Uznanski
	P. L. Vinciguerra	Homer Goldstein		Albert W. Ray, Jr.	John D. Walter
	Eugene Pitts	David S. Helberg		Robert J. Becker	Stanley Rousonelos
	Hugh Falls	Albino Bismonte		Herbert V. Fine	Renato Katubig
	James Creath	David Shapiro		Robert Behmer	Jerald Bowman
	David Littman	Robert Ryan		Raymond Hoffman	Judith Giolitto
LASALLE	E. J. Fesco	Richard Schmidt		Jerome Weiskopf	William Kobler
LAWRENCE	R. C. Kirkwood	Larry Herron		F. H. Riordan, III	Richard Krill
LEE	Donald Edwards	Osama A. Almasri		Richard S. Webb	Fred Nathan
LIVINGSTON	Nikhil Kothari	Rajendra Shrivastav		Ronald Meyer	Victor Jay
LOGAN	Glen E. Tomlinson	James Borgerson	WOODFORD	Ronald Davis	Lori Anderson
MACON (2)	H. Gale Zacheis	C. O. Stanley	SBS	David Aizuss	David Olive
	J. Stroyls	C. G. Glen	RPS		

## Cook County Delegates

### *Delegates*

Aaronson, Donald  
Andelman, Samuel L.  
Andersen, James H.  
Armstrong, Claresa  
Bartolome, Juanito  
Berg, Max  
Bhorade, Maruti S.  
Blankshain, Richard  
Bogen, Gilbert  
Bragman, Robert  
Brislen, Andrew J.  
Budrys, Stanley

### *Alternate Delegates*

Ahstrom, James, Jr.  
Banuchi, Fedor F.  
Beck, Charles A.  
Bellows, Randall  
Bihl, John  
Bild, Sidney  
Borelli, Nelson  
Branovacki, Eugene  
Brown, Murray C.  
Budrys, Milda  
Burdick, Allison L., Jr.  
Burdick, Allison L., Sr.

### *Delegates*

Nemecek, Raymond W.  
Neskodny, J. F.  
Odiaga-Garcia, Ignacio  
O'Sullivan, Donal D.  
Okner, Henry B.  
Olivar, Adriano  
Ostrowski, Fabian  
Pamintuan, Rodolfo L.  
Panayotou, Irene  
Perritt, Richard  
Peterson, Arthur R.  
Petty, David T.

### *Alternate Delegates*

Murphy, Thomas E.  
Neumann, Helen A.  
Nikurs, Lydia  
Nourbakhsh, M.  
Nosal, Roger  
Palmer, Arthur  
Panton, John H.  
Pantone, Anton M.  
Pill, Michael P.  
Podzamsky, George  
Poma, Pedro A.  
Prombo, Marjorie P.

Burkhead, Howard C.  
Ciskoski, Ronald J.  
Costanzo, Vincent A.  
Cross, Roland R.  
Czeisler, Tibor  
Diffenbaugh, W. G.  
Falloon, Edwin L.  
Farah, George S.  
Filipowicz, Roman I.  
Fischer, Arthur  
Fish, William  
FitzGibbons, James P.

Burke, Edward A.  
Carroll, Catherine G.  
Cermak, Miles  
Chaljub, Najib  
Chreptowsky, Achille  
Christensen, Eldis M.  
Coleman, John M.  
Constantaras, Alexander  
Cornbleet, David H.  
Cucco, Ullisse P.  
DeJong, George A.  
De Trana, Frank A.

Quinlan, Donald  
Razim, Edward A.  
Rice, C. Malcolm, Jr.  
Romanus, Raymond J.  
Rothstein, David A.  
Roy, Shirley  
Ruane, Michael  
Ruzich, Stanley  
Saulys, Vacys  
Cucco, Virendra S.  
Schifano, Joseph  
Schimel, Samuel J.

Pustelnikas, Anthony  
Rebendel, Marek B.  
Rezvan, A.  
Richardson, James M.  
Rodriguez, Ignacio  
Saltiel, Isaac  
Santos, Antonio  
Sarley, Vincent  
Schall, Samuel M.  
Schuetz, John N.  
Schwartz, Malcolm  
Seglin, Melvin N.

Flaherty, B. P.  
Flanagan, C. Larkin  
Frankel, Jerome J.  
Freda, Vincent C.  
Gertz, George  
Goldstein, Henry  
Gonzales, Martin  
Green, Martin W.  
Guerrero, Severo K., Jr.  
Harrod, John  
Hinkamp, Joseph F.  
Hoban, Eugene

DiMarco, Eugene R.  
Diaz, Alfonso  
Elegant, Lawrence D.  
Fabian, Sydney  
Fagan, Peter T.  
Feldman, Sidney  
Forgione, Hebe M.  
Forkosh, David  
Gianasi, Charles  
Gnade, Gerard R.  
Goodman, Harold  
Gorday, Rose L.

Sedlak, Frank  
Seed, Randolph  
Shapiro, Maynard I.  
Shaw, Richard  
Shobris, Martin  
Simon, Arnold  
Sinaiko, Edwin S.  
Smith, C. Otis  
Soboroff, Burton J.  
Solon, Earl U.  
Sperling, Richard L.  
Springer, Harry

Senno, Aref  
Short, Marshall  
Siedentop, Karl H.  
Siedlinski, John  
Strohl, Lee H.  
Study, Robert S.  
Sultan, Thomas R.  
Sutoris, Edward D.  
Talso, Peter J.  
Thampy, Kishore J.  
Tobin, John T.  
Toledo, Jose G.

Hoeltgen, Maurice  
Horton, Loren B.  
Hrejsa, Allen C.  
Hutchison, William A.  
Hyde, John S.  
Jaffe, Harry J.  
Jensen, Harold  
Jirka, Frank J., Jr.  
Joslyn, A. Everett, Jr.  
Kahn, Sidney C.  
Kalsch, Harry E.  
Kaz, Alex H.

Graham, James  
Gueyikian, Berj  
Gutierrez, Antonio  
Gurk, John  
Handler, Jerome L.  
Henry, Harvey  
John, Thomas  
Johnson, M. Anita  
Jones, Richard  
Kass, Harold M.  
Knudson, John A.  
Konecny, Philip

Staley, Warren H.  
Suckow, Earl E.  
Sugar, Sam J.  
Swartz, Robert M.  
Tansey, William J.  
Tekdogan, Mehmet M.  
Thompson, J. Robert  
Tovar, Jorge  
Treister, Michael R.  
Ungar, Jacob  
Walkowiak, Lydia  
Wehrmacher, Wm. H.

Tsatsos, George  
Vargas, Eladio A.  
Varzino, Louis  
Vega, Jesus  
Yon, Mustafa  
Zitek, Russell W.  
Zurita, Victor

Kirschenbaum, M. Barry  
Kobak, Mathew  
Kowal, Roland A.  
Kwinn, Frank C.  
Lagorio, George L.  
Libman, Robert H.  
Lobraico, Rocco V., Jr.  
Lukaszewski, Edwin J.  
MacNerland, Robert H.  
Marshall, William  
Meisenheimer, Martin P.  
Murray, Meredith B.

Landau, Richard L.  
Lipsich, Michael  
Lucina, Pedro A.  
Markoutsas, George C.  
McCabe, Mary Joan  
Meccia, Donald  
Meyenberg, John  
Mikhail, Kamel A.  
Mohr, Dorothy P.  
Muehrcke, Robert C.  
Munoz, Maria  
Muriel, Hugo H.

Williams, Jack  
Xydakis, Stephanos A.



# Officers of County Medical Societies 1980

COUNTY	PRESIDENT	SECRETARY
ADAMS Members: 103-Dist. 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	Julio Del Castillo 1124 Broadway, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
ALEXANDER Members: 9-Dist. 9	Gemo Wong 529 Cross, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
BOND Members: 9-Dist. 7	John K. Dawdy 100 N. Locust, Greenville 62246	Thomas D. Dawdy 100 N. Locust, Greenville 62246
BOONE Members: 23-Dist. 12	Miladen Mijanovich 556 E. Grant, Marengo 60152	John Steinkamp 824 S. Van Buren, Belvidere 61008
BUREAU Members: 40-Dist. 2	Ruben Santos 600 E. 1st St., Spring Valley 61362	Swasdi Pothikamjorn 4040 Progress Blvd., Peru 61354
CARROLL Members: 8-Dist. 12	Eliseo M. Colli 102 E. Washington, Mt. Carroll 61053	Benjamin Sy Savanna Medical Center, Savanna 61074
CASS-BROWN Members: 1-Dist. 6	R.A. Spencer 115 W. 4th St., Beardstown 62618	B.A. DeSulis 115 W. 4th St., Beardstown 62618
CHAMPAIGN Members: 222-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	James C. Nauman 401 E. Springfield, Champaign 61820	H. Ewing Wachter 805 W. Kirby, Champaign 61820
CHRISTIAN Members: 23-Dist. 7	Muhammad T. Salaymeh P.O. Box 322, Taylorville 62568	I. Del Valle 311 S. Main, Taylorville 62568
CLARK Members: 6-Dist. 8	Howard G. Johnson P.O. Box 68, Casey 62420	Eugene P. Johnson P.O. Box 68, Casey 62420
CLAY Members: 7-Dist. 7	Donald L. Bunnell Flora Clinic, Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
CLINTON Members: 12-Dist. 7	Jose R. Sosa Munster St., Germantown 62245	James A. Kirby 401 N. Main, Breese 62230
COLES-CUMBERLAND Members: 49-Dist. 8	Albert Schubert, Jr. 720 4th St., Charleston 61920	Asit P. Basu 921 18th St., Charleston 61920
COOK Members: 8541-Dist. 3 Fred Shwartz Exec. Sec. 515 N. Dearborn St. Chicago, IL 60610	Cyril C. Wiggishoff 25 E. Washington, Chicago 60602	Alfred J. Clementi 675 W. Central Rd., Arlington Hts. 60005
CRAWFORD Members: 12-Dist. 8	Michael W. Elliott Family Practice Clinic, Robinson 62454	W. B. Schmidt Schmidt Clinic, Robinson 62454
DE KALB Members: 60-Dist. 12	Darrell B. Wiley 232 S. Second, DeKalb 60115	William F. Stach 407 W. State St., Sycamore 60178
DE WITT Members: 10-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
DOUGLAS Members: 9-Dist. 8	Grant A. Jones 318 S. Ash, Arthur 61911	Humberto Mondul 111 W. South Central, Tuscola 61953
DUPAGE Members: 672-Dist. 11 Lillian Widmer, Ex. Sec. 26 W. St. Charles Rd. Lombard, IL 60148	Vernon Bartley 223 N. York, Elmhurst 60126	James P. Campbell 322 N. Blanchard St., Wheaton 60187

COUNTY	PRESIDENT	SECRETARY
EDGAR Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
EFFINGHAM Members: 19-Dist. 7	Robert Farmer St. Anthony Mem. Hosp., Effingham 62401	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401
FAYETTE Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth St., Vandalia 62471
FORD Members: 12-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
FRANKLIN Members: 29-Dist. 9	James P. Durham Benton Med. Clinic, Benton 62812	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
FULTON Members: 40-Dist. 4	Marcus A. Quinones 175 S. Main, Canton 61520	Jesse M. Reyes 210 W. Walnut, Canton 61520
GALLATIN Members: 2-Dist. 9		John E. Doyle Ridgway 62979
GREENE Members: 6-Dist. 6	Gary L. Turpin 712 S. College, Greenfield 62044	James C. Reid 712 S. College, Greenfield 62044
HANCOCK Members: 11-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
HENDERSON Members: 2-Dist. 4	Farouk El Khatib Stronghurst Med. Cntr., Stronghurst 61480	Silvino Lindo, Jr. Biggsville 61418
HENRY-STARK Members: 35-Dist. 4	James C. Parsons 648 N. Chicago, Geneseo 61254	Myrna Parungao 625 Page, Kewanee 61443
IROQUOIS Members: 23-Dist. 11	Bela Borsos 207 N. Axtel, Milford 60953	Leslie C. Duis 845 S. 4th, Watseka 60970
JACKSON Members: 81-Dist. 9	Myron T. Potter Box 2347, Carbondale 62901	Kevin K. Mooney 404 W. Main St., Carbondale 62901
JASPER Members: 2-Dist. 8	Juan J. Serra 507 W. Washington, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
JEFFERSON-HAMILTON Members: 35-Dist. 9	Nabil L. Messiha 3454 Broadway, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
JERSEY-CALHOUN Members: 11-Dist. 6	Clyde Wieland McDow Med. Cntr., Maple Summit Rd., Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
JO DAVIESS Members: 8-Dist. 12	David Hockman 300 Summit St., Galena 61036	Wilbur Johnson 300 Summit St., Galena 61036
KANE Members: 311-Dist. 1 H. Michael Wild, Ex. Sec. 202 Campbell Geneva 60134	James Downing 157 S. Lincoln, Aurora 60505	John A. O'Dwyer 34 N. Water, Batavia 60510
KANKAKEE Members: 109-Dist. 11	Donald Parkhurst 401 N. Wall, Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
KENDALL Members: 8-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
KNOX Members: 76-Dist. 4	Arthur C. Watson 575 N. Kellogg St., Galesburg 61401	J. John Loesch 695 N. Kellogg, Galesburg 61401
LAKE Members: 420-Dist. 1 Julia Schulz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	Albino Bismonte 135 N. Greenleaf, Gurnee 60031	J. Vickers Brown 1160 Park Ave. W., Highland Park 60035



COUNTY	PRESIDENT	SECRETARY
LASALLE Members: 107-Dist. 2	Don Morehead 313 W. Madison, Ottawa 61350	Allan L. Goslin 712 N. Bloomington, Streator 61364
LAWRENCE Members: 13-Dist. 8 Ruth Garipey, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Francisco E. Martin 542 N. Main, Bridgeport 62417
LEE Members: 25-Dist. 12	Wilbur L. Stitzel KSB Hosp., 403 E. First St., Dixon 61021	Joseph Elie McNichols Clinic, 120 S. Hennepin Ave. Dixon 61021
LIVINGSTON Members: 28-Dist. 2	Nikhil H. Kothari 407 S. 5th, Fairbury 61739	Karl T. Deterding 612 E. Water, Pontiac 61764
LOGAN Members: 25-Dist. 5	EDWARD Ulrich 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
MACON Members: 166-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	M. Joseph Schrodt 363 S. Main, Decatur 62523	H. L. Wibbels 2300 N. Edward, Decatur 62526
MACOUPIN Members: 17-Dist. 6	Federico P. Macaraeg 211 E. Central, Benld 62009	Robert England 935 Morgan, Carlinville 62626
MADISON Members: 203-Dist. 6	Francisco Dioneda 2044 Madison, Granite City 62040	Norman E. Taylor 95 S. 9th St., E. Alton 62024
MARION Members: 42-Dist. 7	Jerome H. Brodish 407 N. Pleasant, Centralia 62801	W. P. Plassman Box 552, Centralia 62801
MARSHALL-PUTNAM Members: 4-Dist. 2	Joe W. Cannon 202 S. Main, Lacon 61540	Donald M. Gallagher Box 538, Granville, 61326
MASON Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	
MASSAC Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
MCDONOUGH Members: 29-Dist. 4	Stephan Roth Colchester 62326	David Reem 505 E. Grant, Macomb 61455
MCHENRY Members: 80-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Ted L. Rolander 1110 N. Green, McHenry 60050	James H. Mowery 1110 N. Green St., McHenry 60050
MCLEAN Members: 126-Dist. 5 Bernyce Carbery Exec. Sec. 401 W. Virginia Normal 61761	Douglas R. Bey 900 Franklin, Normal 61761	John R. Krueger #1 Medical Hills Dr., Bloomington 61701
MERCER Members: 4-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	
MONROE Members: 10-Dist. 10	Edilberto F. Maglasang 109 W. Legion, Columbia 62236	Chung H. Khan Box 142, Lakeview Dr., Waterloo, 62298
MONTGOMERY Members: 22-Dist. 5	L. George Allen 400 Monroe, Litchfield 62056	James T. Foster 8 Arrowhead Rd., Litchfield 62056
MORGAN-SCOTT Members: 51-Dist. 6	Charles Wilson 814 W. State St., Jacksonville 62650	Eric Giebelhausen 1600 W. Walnut, Jacksonville 62650
MOULTRIE Members: 5-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951

COUNTY	PRESIDENT	SECRETARY
OGLE Members: 18-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
PEORIA Members: 399-Dist. 4 M. John Hanni, Jr., Ex. Sec. 427 1st National Bank Peoria 61602	Henry Boldt 427 1st Nat'l. Bank Bld., Peoria 61602	Frederick Heinzen 427 1st Nat'l. Bank Bld., Peoria 61602
PERRY Members: 13-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
PIATT Members: 4-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
PIKE Members: 10-Dist. 6	Carlos B. Lara 326 W. Washington, Pittsfield 62363	T. C. Bunting 321 W. Washington, Pittsfield 62363
PULASKI Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
RANDOLPH Members: 21-Dist. 10	Carl S. Schlegeter 818 E. Broadway, Sparta 62286	J. M. Whittenberg 1650 State St., Chester 62233
RICHLAND Members: 22-Dist. 8	Paul C. Weber 1200 N. East, Olney 62450	Arcot D. Suresh 1200 N. East St., Olney 62450
ROCK ISLAND Members: 197-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	William Dougherty 4602 3rd St., Moline 61265	Miguel Flores 532 19th, Moline 61265
ST. CLAIR Members: 254-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main Belleville 62223	H. Frank Holman Oliver Anderson Hosp., Maryville 62062	Robert C. Wanless 6401 W. Main, Belleville 62223
SALINE-POPE-HARDIN Members: 31-Dist. 9	William B. Skaggs 203 N. Vine, Harrisburg 62946	Warren R. Dammers P.O. Box 281, Harrisburg 62946
SANGAMON Members: 362-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza Springfield 62701	P. F. Mahon 1 N. Old State Capitol Plaza Springfield 62701	Twofig, Arjmand 1307 S. 7th St., Springfield 62703
SCHUYLER Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
SHELBY Members: 8-Dist. 7	Theodore Little 207 S. Pine, Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
STEPHENSON Members: 56-Dist. 12	James McGath 1815 W. Church, Freeport 61032	George Lagen 1045 W. Stephenson, Freeport 61032
TAZEWELL Members: 65-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Terry Tosi P.O. Box 778, Pekin 61554	Robert F. Gregorski P.O. Box 778, Pekin 61554
UNION Members: 8-Dist. 9	Thomas W. Davis 200 N. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Anna 62906
VERMILION Members: 99-Dist. 8	Angelo Anaclerio 1104 N. Vermilion, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
WABASH Members: 5-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863



COUNTY	PRESIDENT	SECRETARY
WARREN Members: 14-Dist. 4	Richard Icenogle Box 188, Roseville 61473	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 6-Dist. 10	Ralph Kelly 113 W. St. Louis, Nashville 62263	Methee Vanadilok 111 S. Washington, Nashville 62263
WAYNE Members: 9-Dist. 9	Charles J. Jannings 101 E. Center, Fairfield 62837	Arthur R. Marks 101 E. Center St., Fairfield 62837
WHITE Members: 8-Dist. 9	John Stricklin West Main St., Carmi 62821	Julius Harrell Doctor's Clinic, Carmi 62821
WHITESIDE Members: 52-Dist. 12	Richard A. Londo 204 N. Jackson, Morrison 61270	Reda Salama 1714 Gregden Shores, Sterling 61081
WILL-GRUNDY Members: 253-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	John W. Bowden 330 Madison, Joliet 60435	Robert G. Olsen 120 Scott, Joliet 60431
WILLIAMSON Members: 35-Dist. 9	Robert Kane 120 W. Walnut, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
WINNEBAGO Members: 383-Dist. 12 Robert Carlson Exec. Adm. 310 N. Wyman St. Rockford 61101	Richard S. Webb, Jr. 2500 N. Rockton, Rockford 61103	Bernard O'Malley 5670 E. State St., Rockford 61108
WOODFORD Members: 7-Dist. 2	Joseph C. Phifer 203 S. Main, Eureka 61530	James W. Riley 109 S. Major, Eureka 61530

#### No Organized County Society

Edwards  
Johnson  
Menard

#### Joint County Societies

Cass-Brown	Marshall-Putnam
Coles-Cumberland	Morgan-Scott
Henry-Stark	Saline-Pope-Hardin
Jefferson-Hamilton	Will-Grundy
Jersey-Calhoun	

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the reference section. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 TELEPHONE: (    ) \_\_\_\_\_  
 COUNTY MEDICAL SOCIETY: \_\_\_\_\_  
 MEDICAL SPECIALTY AND TYPE OF PRACTICE: \_\_\_\_\_  
 COMMITTEE IN WHICH INTERESTED: \_\_\_\_\_  
 EXPERTISE FOR THIS COMMITTEE: \_\_\_\_\_

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society  
 55 E. Monroe, Suite 3510, Chicago, IL 60603

# **Committees of the House of Delegates**

## **1980 Interim Meeting**

### **COMMITTEE ON RULES & ORDER OF BUSINESS**

This committee shall consider all matters regarding rules governing actions, methods and procedures, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

### **COMMITTEE ON CREDENTIALS**

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

### **TELLERS AND SERGEANTS AT ARMS**

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

### **REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS**

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

### **REFERENCE COMMITTEE A**

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to officers, administration, finances, budgets, economics and peer review.

### **REFERENCE COMMITTEE B**

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports relating to government health programs and planning.

### **REFERENCE COMMITTEE C**

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to medical service, scientific matters, education and membership services.

### **REFERENCE COMMITTEE D**

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to governmental affairs, medical-legal, and public relations matters.



# ISMS DELEGATION TO THE AMA

## Delegates

*To serve from Jan. 1, 1979 to Dec. 31, 1980  
(Elected April 5, 1978)*

Allison L. Burdick, Jr., Chicago  
David S. Fox, Chicago  
Henrietta Herbolsheimer, Chicago  
Lawrence L. Hirsch, Chicago  
Joseph R. O'Donnell, Glen Ellyn  
John J. Ring, Mundelein  
Charles K. Wells, Mt. Vernon  
George T. Wilkins, Granite City

*To serve from Jan. 1, 1980 to December 31, 1981  
(Elected May 9, 1979)*

Herschel Browns, Chicago  
Howard C. Burkhead, Evanston  
Jack L. Gibbs, Canton  
Theodore Grevas, Rock Island  
Morgan M. Meyer, Lombard  
Maynard I. Shapiro, Chicago  
Joseph Skom, Chicago

*To serve from Jan. 1, 1981 to Dec. 31, 1982  
(Elected April 15, 1980)*

David S. Fox, Chicago  
Morris T. Friedell, Chicago  
Henrietta Herbolsheimer, Chicago  
Lawrence L. Hirsch, Chicago  
Joseph R. O'Donnell, Glen Ellyn  
John J. Ring, Mundelein  
Glen E. Tomlinson, Lincoln  
George T. Wilkins, Granite City

## Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.  
Edwin S. Hamilton, Kankakee  
Frank J. Jirka, Jr., Barrington Hills  
Burtis E. Montgomery, Long Island, NY

*Delegation Chairman: Herschel Browns; Secretary: Theodore Grevas*

## Alternate Delegates

*To serve from Jan. 1, 1979 to Dec. 31, 1980  
(Elected April 5, 1978)*

Andrew J. Brislen, Chicago  
Alfred Clementi, Arlington Heights  
Audley F. Connor, Jr., Chicago  
Morris T. Friedell, Chicago  
Robert P. Johnson, Springfield  
Boyd McCracken, Greenville  
Clifton L. Reeder, Wilmette  
P. John Seward, Rockford

*To serve from January 1, 1980 to December 31, 1981  
(Elected May 9, 1979)*

Allan L. Goslin, Streator  
Robert Hamilton, Chicago  
Robert R. Hartman, Jacksonville  
Eugene P. Johnson, Casey  
Lee Johnson, Litchfield  
Harold Lasky, Chicago  
Cyril C. Wiggishoff, Chicago

*To serve from Jan. 1, 1981 to Dec. 31, 1982  
(Elected April 15, 1980)*

Andrew J. Brislen, Chicago  
Alfred Clementi, Arlington Heights  
Audley F. Connor, Jr., Chicago  
Robert P. Johnson, Springfield  
Boyd McCracken, Sr., Greenville  
Clifton L. Reeder, Wilmette  
Richard Rovner, Chicago  
P. John Seward, Rockford

# **ILLINOIS DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION REPORT TO THE HOUSE OF DELEGATES**

The Illinois Delegation to the AMA introduced four resolutions for consideration by the House of Delegates at the 1980 annual AMA meeting in Chicago. Following is the action taken on each:

*Resolution 99: Fund Solicitation by Persons Affiliated with Health Systems Agencies.* Amended and adopted—"Resolved, That the AMA request the Congress of the United States to enact legislation and to request the Bureau of Health Planning to prohibit fund solicitation activities or acceptance of such non-federal funds by any Health Systems Agency."

*Resolution 100: CPT-4 Coding for Medicare Reimbursement.* Amended and adopted as follows—"Resolved, That the American Medical Association work toward implementing the nationwide use of Current Procedural Terminology, 4th Edition, (CPT-4) for all third party payors' physician services identification, with emphasis on a five-digit code."

*Resolution 101: Specialty Board Test Questions on Treatment of Rape Victims.* Substitute adopted—"Resolved, That the AMA prepare and disseminate information intended to maintain and improve the skills needed by all practicing physicians involved in providing care to rape victims."

*Resolution 102: Moratorium on Mandatory Continuing Medical Education.* Adopted—"Resolved, That the American Medical Association request the cooperation of all specialty societies and state medical societies in supporting a moratorium on all additional mandatory continuing education or any mandatory re-examination or recertification programs, pending evidence of their effectiveness in upgrading the competence of physicians."

During the meeting word was received of the death of Dr. William K. Ford, former chairman of the Illinois Delegation. A memorial resolution was prepared and adopted by the House.

Report B. of the Ad Hoc Committee on the Principles of Medical Ethics created the most interest among the delegates. By adopting the report, the House revised the Principles. Following is the 1980 version:



## Principles of Medical Ethics

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Because of the controversial nature of these revisions, the delegation has asked Dr. Henrietta Herbolzheimer, who is both a member of the Illinois Delegation and the Ad Hoc Committee, to address the ISMS House of Delegates on this subject in October.

Other highlights of the meeting were the elections of:

Dr. Jack Gibbs to the Council on Medical Education  
Dr. John Ring to the Council on Medical Service (re-elected)  
Dr. Ann Nunnally to the resident position on the Council on Medical Education  
Dr. David Olive as secretary of the AMA Resident Physicians Section  
Dr. Larry Gratkins as RPS alternate delegate to AMA  
Mr. Ronald Davis as SBS delegate to AMA

Dr. Robert Johnson and later Dr. Glen Tomlinson were seated as delegate in place of Dr. George Wilkins, who was unable to attend the meeting. Ronald Davis, SBS representative, and Dr. Ira Friedlander, RPS representative, were credentialed as alternate delegates in place of Drs. Andrew Brislen and Robert Hamilton, who were not present.

Herschel Browns, M.D.  
Chairman

Theodore Grevas, M.D.  
Secretary

# SCHEDULE OF MEETINGS

## INTERIM HOUSE OF DELEGATES

October 25-26, 1980

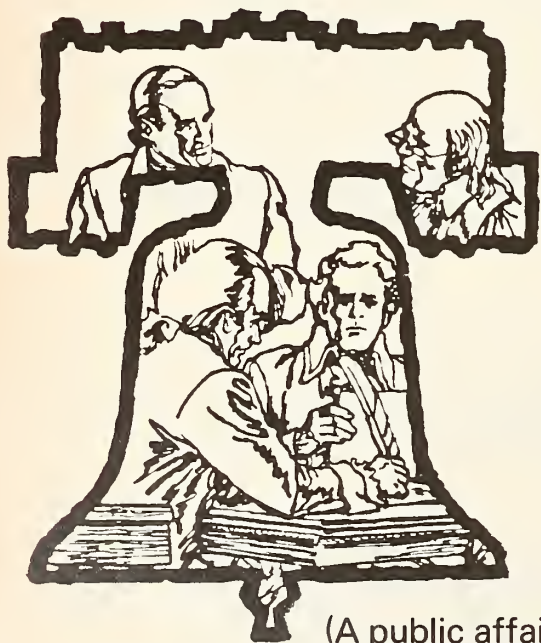
Continental Regency  
Peoria, Illinois

### Saturday, October 25, 1980

- |            |  |
|------------|--|
| 8:30 a.m.  | Delegates Registration Opens   |
| 9:30 a.m.  | Meeting of Reference Committee Personnel   |
| 10:00 a.m. | Delegates Check-In with Credentials Committee (Shrine Temple)  |
| 10:30 a.m. | House of Delegates Meeting (Shrine Temple)   |
| 11:30 a.m. | IMPAC Interim Meeting<br><i>District Caucuses: Immediately Following End of First Session (In Hotel)</i> |
| 12:30 p.m. | Delegates Luncheon   |
| 2:00 p.m.  | Reference Committee Meetings   |
| 6:00 p.m.  | Public Affairs Program   |

### Sunday, October 26, 1980

- |           |   |
|-----------|---|
| 8:00 a.m. | District Caucuses                             |
| 9:00 a.m. | Delegates Check-In with Credentials Committee |
| 9:30 a.m. | House of Delegates Meeting                    |



*The Public Affairs Committee  
Cordially invites  
All Interim Meeting Participants  
To preview  
"Government"*



(A public affairs production of the Interlake Corporation)  
Saturday, October 25, 1980, 6:00 p.m. Continental Regency Hotel,  
Peoria, Illinois  
Light refreshments available upon conclusion of program



# Resolutions for 1980 Interim Session

## ISMS House of Delegates

The following resolutions were received at ISMS headquarters by August 23 and, according to provisions of the bylaws, are printed in IMJ by title and subject. As a result of recent action by the House of Delegates, the Committee on Rules and Order of Business is responsible for recommending whether or not resolutions submitted by individual delegates will be considered by the House at an interim session or held over for the next annual meeting.

Final deadline for resolutions is September 27. At this writing, it is anticipated that other resolutions will have been submitted and accepted for consideration before that deadline. These will be included in the Delegates' Packet of materials.

<i>Number:</i>	<i>Introduced by:</i>	<i>Subject</i>
801-1	Alfred J. Kiessel, M. D., for the Board of Trustees and the Council on Medical Services	Deletion of Policy Manual Statement on "Occupational Health"
801-2	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Public Relations and Membership Services	Amendment of Policy Manual Statement on "Press"
801-3	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Public Relations and Membership Services	Deletion of Policy Manual Statement on "Membership in Paramedical and Service Organizations"
801-4	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Public Relations and Membership Services	Deletion of Policy Manual Statement on "Membership of Osteopathic physicians in ISMS"
801-5	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Public Relations and Membership Services	Deletion of Policy Manual Statement on "Public Safety"
801-6	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Public Relations and Membership Services	Deletion of Policy Manual Statement on "Surveys"
801-7	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Public Relations and Membership Services	Replacement of the ISMS Policy Statement on "Athletic Programs"
801-8	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Public Relations and Membership Services	Replacement of ISMS Policy Statement on "Reference Service"
801-9	Arthur Traugott, M.D., for the Champaign County Medical Society	Final Disciplinary Action and Reporting By the Illinois Department of Registration and Education

# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

### NOTICE OF SPECIAL IMPAC MEETING

The Illinois Medical Political Action Committee will meet in special session in conjunction with the ISMS Interim Meeting, scheduled for October 25-26, 1980 in Peoria, Illinois to consider changes in the IMPAC Constitution and Bylaws necessitated by recent rulings by the Federal Election Commission. That meeting is scheduled as follows:

Saturday, October 25, 1980

Immediately following the adjournment of the House of Delegates

Shrine Temple (located across the street from the Continental Regency Hotel)  
Peoria, Illinois.

All IMPAC members are encouraged to attend. The changes in the Constitution are as follows:

PREAMBLE: We members of the medical profession, ~~our wives and associates~~ do hereby band together to exert our collective influence for better government through political action and education.

ARTICLE I - NAME: The name of this organization shall be the Illinois State Medical Society Political Action Committee, hereinafter referred to as IMPAC.

ARTICLE V - MEMBERSHIP: There shall be three (3) classes of membership in IMPAC, ~~viz: Regular, Sustaining, Special, as hereinafter defined.~~ All such classes shall be entitled to those benefits as enumerated in Article VI.

~~Section 2:~~ a) Regular Membership. Any Doctor of Medicine who is a member in good standing of his county and state medical society, ~~and his or her spouse,~~ may become a regular member upon payment of dues.

b) Member. Any individual who pays dues voluntarily to IMPAC may become a member.

~~bc)~~ Sustaining Membership. ~~Any Doctor of Medicine who is a member in good standing of his county and state medical society, and his or her spouse, may become a sustaining member.~~ Any individual who meets the criteria of Sections 1a and 1b may become a sustaining member upon payment of dues.

~~c)~~ Special Membership. ~~One or more categories of special membership may be established by the Council under terms and conditions specified by the Council.~~

ARTICLE VIII - OFFICERS AND EXECUTIVE COMMITTEE OF THE COUNCIL: Section 6,c) The Secretary-Treasurer shall be the custodian of all the funds and official records of IMPAC. He shall cause all funds to be deposited and/or invested and all records to be kept in accordance with directives of the Council. He shall disburse the funds of IMPAC in the manner authorized by the Council subject to any applicable provisions of the law with respect thereto. He shall present a report at the annual meeting, meetings of the Council, and at such other times as requested by the Council or Executive Committee. He shall sign, and file all reports required of IMPAC by law.

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.



# EKG

(Continued from page 183)

**Answers: 1. A. B. 2. C.**

The top two ECG rhythm strips show a junctional tachycardia with P waves marching through the QRS complexes. As in the fourth beat in the top ECG strip, there are occasional sinus capture beats creating an incomplete atrioventricular dissociation. The P waves had a large negative component which suggested left atrial enlargement. There is no evidence here for acute myocardial infarction or ventricular tachycardia. Just prior to administration of the sodium bicarbonate, a serum potassium was drawn. It was 6.8 mEq/liter, in keeping with hyperkalemia. The common ECG effects of hyperkalemia are peaking of the T wave, widening of the QRS complex and disappearance of the P wave. PR interval prolongations and slowed intra-atrial conduction have been seen. Further increases in serum potassium can lead to ventricular standstill or fibrillation. Although there is only a rough correlation between ECG changes and levels of serum potassium, the ECG is useful for providing rapid directional

changes in potassium levels. Since hyperkalemia is a life-threatening emergency, prompt treatment is required. One or two ampoules of sodium bicarbonate can be given immediately intravenously. Calcium chloride and calcium gluconate have also been used successfully. Serum calcium will immediately antagonize the elevated potassium while sodium bicarbonate may actually lower potassium especially in the presence of acidosis. Glucose and insulin combinations, as well as ion-exchange resins (Kayexalate) can be given afterwards. Finally dialysis may be required. Our patient had poorly responsive congestive heart failure. This prompted the use of larger doses of diuretics. That resulted in a pre-renal azotemia, a BUN of 75 mg %, and hyponatremia-serum sodium 125 mEq/liter. In this setting, he developed a septicemia which was treated with large doses of aqueous penicillin G. Every million units of aqueous penicillin G contains 1.6 mEq of potassium. Therefore, the pre-renal azotemia, hyponatremia, and potassium load from the penicillin combined to create hyperkalemia. This cardiac arrhythmia is rarely ascribed to hyperkalemia. Although he had many medical problems including hyperkalemia, only the latter could be so promptly reversed with sodium bicarbonate. ◀

## PHYSICIANS

Full-time Physicians to work in the Chicago Department of Health's Venereal Disease Control Program. Ideal for young physicians awaiting residency training and for former military physicians or for physicians who have left private practice who wish to remain professionally active in the field of sexually transmitted diseases.

Requirements: Illinois Licensure, Residence within the City of Chicago. Salary: Depends on training.

*For further details contact:*

**George R. Adam, M.D.**  
**312/842-0242**

*The City of Chicago is an Equal Opportunity and Affirmative Action Employer M/F*

## Cook County Graduate School of Medicine CONTINUING EDUCATION COURSES

### **A. M. A. Accredited**

### **November 1980 - January 1981**

**Diagnosis & Management: The Acute Cardiac Patient**  
November 5-7, 1980

**Advances In Internal Medicine**  
November 10-14, 1980

**Flexible Fiberoptic Sigmoidoscopy**  
November 15, 1980

**Thoracic Surgery: A Specialty Review**  
December 1-5, 1980

**Urologic Pathology and Radiology: A Specialty Review**  
December 8-11, 1980

**Specialty Review in Surgery, Part II**  
January 12-23, 1981

**Fiberoptic Colonoscopy**  
January 21-23, 1981

*For further course offerings, information and registration, please write or call.*

**Cook County Graduate School of Medicine**  
**707 South Wood Street, Chicago, Illinois 60612**  
**(312) 733-2800**

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ATKINSON:** A modern clinic with all facilities is available to a family physician who wants security and a wonderful place to practice. Hammond-Henry Hospital only 8 miles away. Excellent grade and high schools and near Black Hawk Junior College. 30 miles to Quad City area, 140 miles to Chicago and 60 miles to Peoria (UI). All recreational facilities nearby. CONTACT: John W. Ellis, Mayor, Atkinson 61235 (309-936-7566). (11)

**CARBONDALE:** Primary care physician (M.D. or D.O.) for Health Service at prominent university which includes an aggressive wellness program and a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. Ability to fluently converse in English and IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, 62901. (11)

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## Viewbox

(Continued from page 167)

### ANSWER: TRANSLUMINAL ANGIOPLASTY

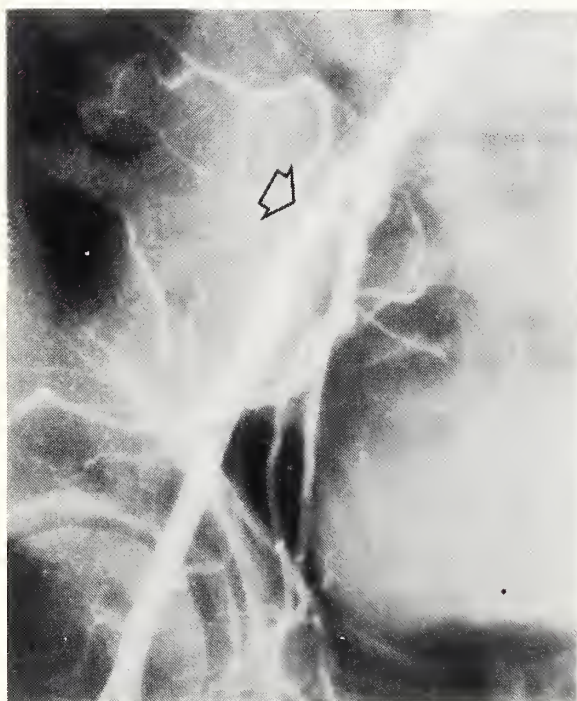


Figure 3 Patient A



Figure 4 Patient B

Although both patients could have been treated with the more familiar surgical procedures both were successfully treated by percutaneous transluminal angioplasty. Due to the complexity of patient B's medical problems he was not considered a suitable candidate for aorto-iliac bypass, but it was originally planned to supplement the catheter dilatation of the iliac artery lesion with a femoropopliteal bypass graft when his condition improved. However, his foot ulcer began to heal soon after angioplasty and it was elected to postpone supplemental surgical intervention indefinitely. Patient A did not want surgery or the period of post-operative convalescence. Excellent arterial pulsations were palpable in his ankle and foot immediately after dilatation of the segmental stenosis. He noted immediate improvement in his symptoms following angioplasty and was able

to return to work within a few days.

Percutaneous transluminal angioplasty was first described in 1963 and became a popular mode of treatment of atherosclerotic disease in Europe while remaining little used in the United States. With the introduction of the Gruentzig balloon catheter dilatation system in 1976 the technique has gained wider acceptance in this country. Currently atherosclerotic as well as fibromuscular dysplastic lesions in most major vessels including the renal arteries, the coronary arteries, the aorta, the subclavian arteries, the vertebral arteries, the mesenteric arteries, iliac, and the more peripheral lower extremity arteries have been treated successfully. Stenotic lesions which develop in arterial bypass grafts as well as in A-V fistulas and shunts used for renal dialysis have also been successfully dilated. Balloon cath-



eter dilatation of stenosed or occluded arteries is little more than an extension of widely used and accepted angiographic techniques for the pre-operative evaluation of vascular disease. The risks associated with angioplasty are similar to those of angiography alone.

Isolated short stenotic lesions are ideal for treatment by angioplasty. Longer stenotic lesions, multiple stenosis or even completely occluded vessels can also be treated, but results in these vessels are significantly less satisfactory. It is generally accepted that vessels which are occluded over distances greater than 5cm should be bypasses surgically. However, in those cases where surgical intervention is contraindicated due to the patient's overall poor condition, angioplasty of very long lesions can be attempted in an effort to salvage a limb which might otherwise require amputation. Very gratifying results have been obtained in such instances.

By the use of balloon catheter dilatation in properly selected patients, up to 90% of lesions can be immediately relieved. Perhaps 20% will require either retreatment by balloon dilatation because of recurrence or a surgical procedure to correct additional lesions not amenable to balloon dilatation. In many patients angioplasty is complementary to planned surgical reconstructive

procedures because it may simplify surgery or permit a choice of operations associated with lower morbidity and/or mortality.

When angioplasty is done skillfully the risks associated with general anesthesia and surgery are eliminated and the usual period of post operative convalescence is reduced literally from weeks to hours. In many instances the procedure can be done on an outpatient basis or the patient hospitalized for only one or two days. Although extremely long term follow up studies are unavailable, it appears that angioplasty is at least as effective as surgery in the treatment of appropriate lesions and its utilization can result in considerable savings of time and cost to the patient. ◀

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Please give us your present office address; your new office address; your identification code number; city, state, zip code; and the **EFFECTIVE DATE OF THE ADDRESS CHANGE**. The latter is important so we know when to send your new "Physician's Service Report" forms.

Send this information to the Blue Cross & Blue Shield Plan, 233 North Michigan Avenue, Chicago, Illinois 60601—Attn: Provider File Department 7th floor. When you receive your new forms, please destroy the old ones.

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### Update on Medical Necessity Project

Since the Medical Necessity Project was first introduced in 1977, additional experience with the program has been accumulated and some new judgments have been made.

In this regard, the American College of Surgeons has recommended to the Blue Cross and Blue Shield Associations, and the Boards have approved, that the radical hemorrhoidectomy, Whitehead type, including removal of the entire pile bearing area, no longer be included in the Project. Special justification is no longer required in order for

Plans to pay benefits for this procedure.

The American College of Surgeons' action was prompted by the American Society of Colon and Rectal Surgeons, which requested that the procedure be deleted from the project. After studying the Society's request, and reviewing additional evaluative information, the College concurred.

The Chicago-based Blue Cross and Blue Shield Plan has removed this procedure from the list of procedures now included in the Medical Necessity Project.

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See consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or cimetidine Bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librax<sup>®</sup> (chlordiazepoxide HCl/Roche) to known addicts.

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

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# EKG of the Month

Contributing Editors: John F. Maron, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlan, M.D., Sarah A. Johnson, M.D., John R. Tabin, M.S., M.D., and Rolf M. Gunnor, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This is a fifty-six year old woman who complained of episodic lightheadedness for the past five months. She had suffered spells of anxiety for many years and had intermittently taken diazepam for relief. Her complaints had included dizziness, buzzing in the head, palpitations, and occasional nausea. However, she felt the lightheadedness was a new sensation and she wondered if this also could be caused by "nerves." She was able to work every day but would have to put her head down on her desk for relief of the lightheadedness. These lightheaded spells only lasted ten to fifteen minutes and were never associated with syncope. They were occurring on a daily basis of late. Her physical examination was normal except for an irregular heart beat. Her resting ECG was known to have been abnormal for the past five years. The lead  $V_1$  rhythm strip was recorded.*

## Questions:

**1. The lead  $V_1$  rhythm strip shows:**

- A. A QRS pattern compatible with complete right bundle branch block.
- B. Type II second degree atrioventricular (AV) block (Mobitz).
- C. Type I second degree AV bloc (Wenckebach).
- D. Premature ventricular beats, occasionally in bigeminy.

E. An irregular, accelerated idioventricular rhythm.

**2. The non-invasive test that is most likely to be helpful in this patient is:**

- A. An echocardiogram, both M-mode and two dimension sector scan.
- B. An ambulatory ECG (Holter monitor recording).
- C. A multistage exercise ECG.
- D. A vectorcardiogram.

*(Continued on page 352)*



# Abstracts of Action

September 13-14, 1980

Chicago

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## MEMBERSHIP RECRUITMENT

In accordance with a House of Delegates directive, ISMS will launch a new member recruitment program in concert with AMA and county medical societies. ISMS will:

- Request AMA to distribute its biweekly report, "AMA Highlights", to all non-members, followed by a recruitment letter from the AMA president.
- Mail a new ISMS membership benefits booklet to all non-members with a letter inviting them to join the Society.
- Provide a list of local non-member physicians to each county society with a request to follow the AMA and ISMS membership promotion letters with one of its own.

To offset some of the new member promotional costs borne by county societies, ISMS will transmit the full AMA commission it receives for early dues transmittal to those societies which: (1) Assist in the dues collection process; and (2) Abide by the "Criteria for AMA Dues Billing and Remittance."

## FRIEND-OF-THE-COURT BRIEF

ISMS will file a friend-of-the-court brief supporting Central DuPage Hospital's appeal of a court ruling—issued in a malpractice suit—which could jeopardize the confidentiality of patients' hospital records. The Board ratified an Executive Committee decision to file the brief aimed at overturning the trial court's ruling that a hospital must release patient records despite the statutory confidentiality granted to the physician-patient relationship.

In a suit charging negligent use of a drug called Discase, a circuit court ruled that Central DuPage Hospital, Winfield, must release—after eliminating names and addresses—medical records of: (1) 800 patients treated with the drug; and (2) All patients admitted to the hospital by a particular physician. The hospital administrator refused to comply with the order and was cited for contempt of court.

## COMMON CLAIM FORM

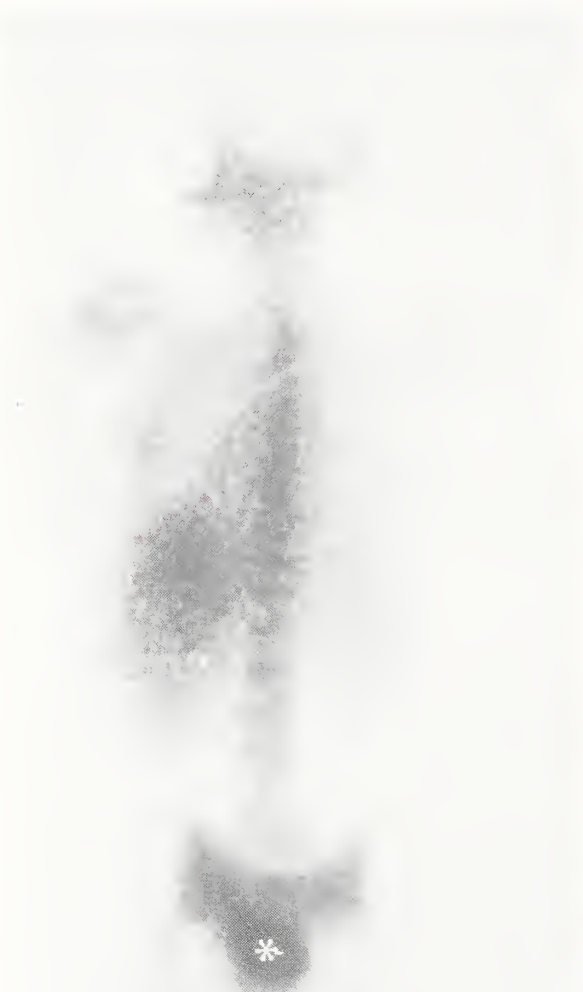
The Society will seek approval of a common claim form by all third party payors if the form is accepted by IDPA and Electronic Data Systems-Federal (EDS-F). ISMS has been working with IDPA and EDS-F to develop a form—utilizing data elements of the AMA's model Uniform Claim Form—which will simplify physicians' paperwork.

*(Continued on page 348)*

# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*These three post-operative patients had surgery less than two weeks ago. They are all febrile. They all have the same diagnosis.*



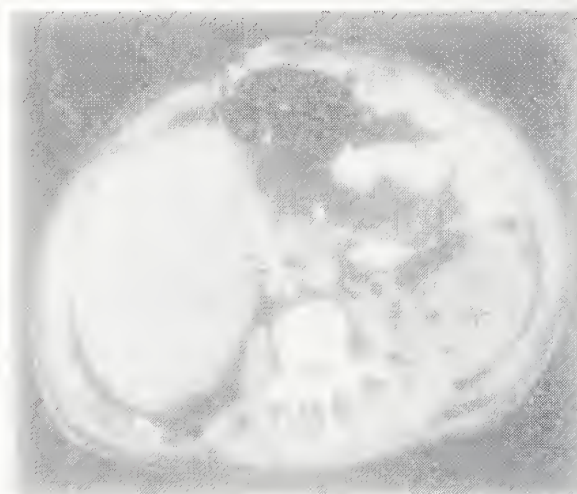
**Figure 1**

Patient I Gallium-67 scan, tomographic section of posterior pelvis just anterior to sacrum. (Asterisk = abnormality)



**Figure 2**

Patient II Longitudinal ultrasound scan near the midline. (B = bladder; Asterisk = abnormality)



**Figure 3**

Patient III Computed tomographic section of upper abdomen following splenectomy. (L = liver; Asterisk = abnormality)

## ***Your diagnosis?***

- (1) Urinoma
- (2) Abscess
- (3) Hematoma
- (4) Necrotic neoplasm
- (5) Distended bowel loops

*(Continued on page 353)*



# Pulse of the ISMS Auxiliary

## AMAA—A Sound Investment

BY MRS. HARLAN FAILOR, ISMSA PRESIDENT



AMA Auxiliary Convention  
Delegates and Alternates

1st row (l to r): Mrs. Don Hinderliter, Mrs. Harold Keegan, Mrs. Harlan Failor, Mrs. R. S. Hoover, Mrs. Edward Szewczyk.

2nd row (l to r): Mrs. Irvin Blumfield, Mrs. Robert Hartman, Mrs. Karl Reddies, Mrs. Selig Hodes, Mrs. August Martinucci, Mrs. Henry Schorr, Mrs. Joseph Cari.

3rd row (l to r): Mrs. Wendell Roller, Mrs. Gamil Arida, Mrs. Wayne Kassel, Mrs. Mitchell Spellberg, Mrs. Eugene Vickery.

In time of inflation when we are all concerned about the return on our money, it is not surprising that county Auxilians are asking, "What am I *getting* for my AMA Auxiliary dues? The question is posed even more frequently this year, because in 1980 national dues went from \$7 to \$11, and another \$4 raise has been approved for 1982—a total increase of 114% in three years.

In my estimation, there are two benefits well worth the price of AMAA membership: the magazine FACETS, now published five times annually, and the AMAA sponsored Leadership Confluence held in Chicago each Fall.

FACETS is sent to every member of the national Auxiliary. It contains accounts and pho-

tographs of unique and interesting county activities ("Vial of Life Aids Rescuers") and articles relating to the medical family ("The Physician's Marriage: Joys and Sorrows"). Each issue covers a variety of timely topics. Examples from the past year include features on the following topics—

*Mental and Physical Health:* "Midlife: Crisis or Challenge," and "Shape Up for Life: Goodbye to Feast or Famine."

*Training:* "How To Use Audio Visuals," and "Savvy Speaking."

*Current Issues:* "Joining Forces Against Child Abuse," and "The Commitment to Cost Containment."

*Financial Planning*: "What's Your Tax IQ?" and "The Ins and Outs of Practice Management."

Doctors, as well as their spouses, can benefit from a perusal of this well written and informative magazine.

The AMAA Leadership Confluence, though restricted in attendance, can benefit all Auxilians in Illinois. The excellence and breadth of the Confluence program make it a valuable resource, and for this reason the Illinois State Medical Society Auxiliary purchases, every year, audio cassettes of all Confluence seminars and speeches. These are available to ISMSA members and may be borrowed by writing to Mrs. Jane Swanson, ISMSA Executive Secretary, 104 East Broadway, Monmouth, Illinois 61462. The only cost involved is the return postage. Subjects covered in the 1980 Leadership Confluence were divided into two categories:

*Leadership Seminars—You and the Auxiliary*

- "Writing, Art, and Layout"
- "Parliamentary Procedure"
- "Building Membership: Methods and Motivation"
- "Management of Time"

- "Techniques for Speakers"
- "Assertiveness Training"

*Topic Seminars—Health and the Family*

- "Physical Fitness"
- "Prescription Drug Abuse"
- "Health Education in the Schools"
- "Parenting"
- "Child Passenger Safety"
- "Coping with Youth"

A listing of all available tapes may be obtained from the Auxiliary's Monmouth office.

Add to these benefits a Project Bank with over 900 ready-made projects from fund raising to child safety; an array of Package Programs such as "Mental Health" and "Services to Aging"; resource people, films, and slide presentations—all at no extra charge.

Materials, training, education, services—everything you need (except the local volunteers) to improve health and quality of life in your community—and for less than a dinner out or a theater ticket. With "earnings" many times the "price," with "dividends" exceeding the "investment," what does it cost to belong to the AMA Auxiliary? It doesn't *cost*, it *pays* to belong! ◀

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# OBITUARIES

**\*Allen, Elmer S.**, Arcola, died August 31, 1980, at the age of 72. Dr. Allen was a 1935 graduate of Tulane University School of Medicine and a former president and secretary of the Douglas County Medical Society.

**\*Cameron, Don S.**, Peoria, died August 24, 1980, at the age of 73. Dr. Cameron was a 1931 graduate from the University of Colorado Medical School.

**\*\*Crean, Chester L.**, Chicago, died July 5, 1980, at the age of 76. Dr. Crean was a 1927 graduate of the University of Illinois Medical School. Formerly the staff president at Augustana Hospital, Dr. Crean was also a former president of the Northwest and the North Shore Branches of the Chicago Medical Society.

**\*Kruse, George Francis**, Chicago, died September 20, 1980, at the age of 72. Dr. Kruse was a 1933 graduate of the Loyola University Stritch School of Medicine and also earned a law degree from Loyola in 1945.

**\*Rezek, George Henry**, Riverside, died September 13, 1980, at the age of 75. Dr. Rezek was a 1933 graduate from the University of Illinois Medical School.

**\*\*Torczynski, Vincent Francis**, Chicago, died September 5, 1980, at the age of 80. Dr. Torczynski was a 1925 graduate of the Loyola University Stritch School of Medicine.

**\*\*Tsoulos, George D.**, Chicago, died September 19, 1980, at the age of 81. Dr. Tsoulos was a 1928 graduate of Rush Medical College.

**\*Weiss, Marvin A.**, Chicago, died September 6, 1980, at the age of 53. Dr. Weiss was a 1949 graduate of the University of Illinois Abraham Lincoln School of Medicine.

\* Indicates ISMS member

\*\*Indicates ISMS member of the fifty year club



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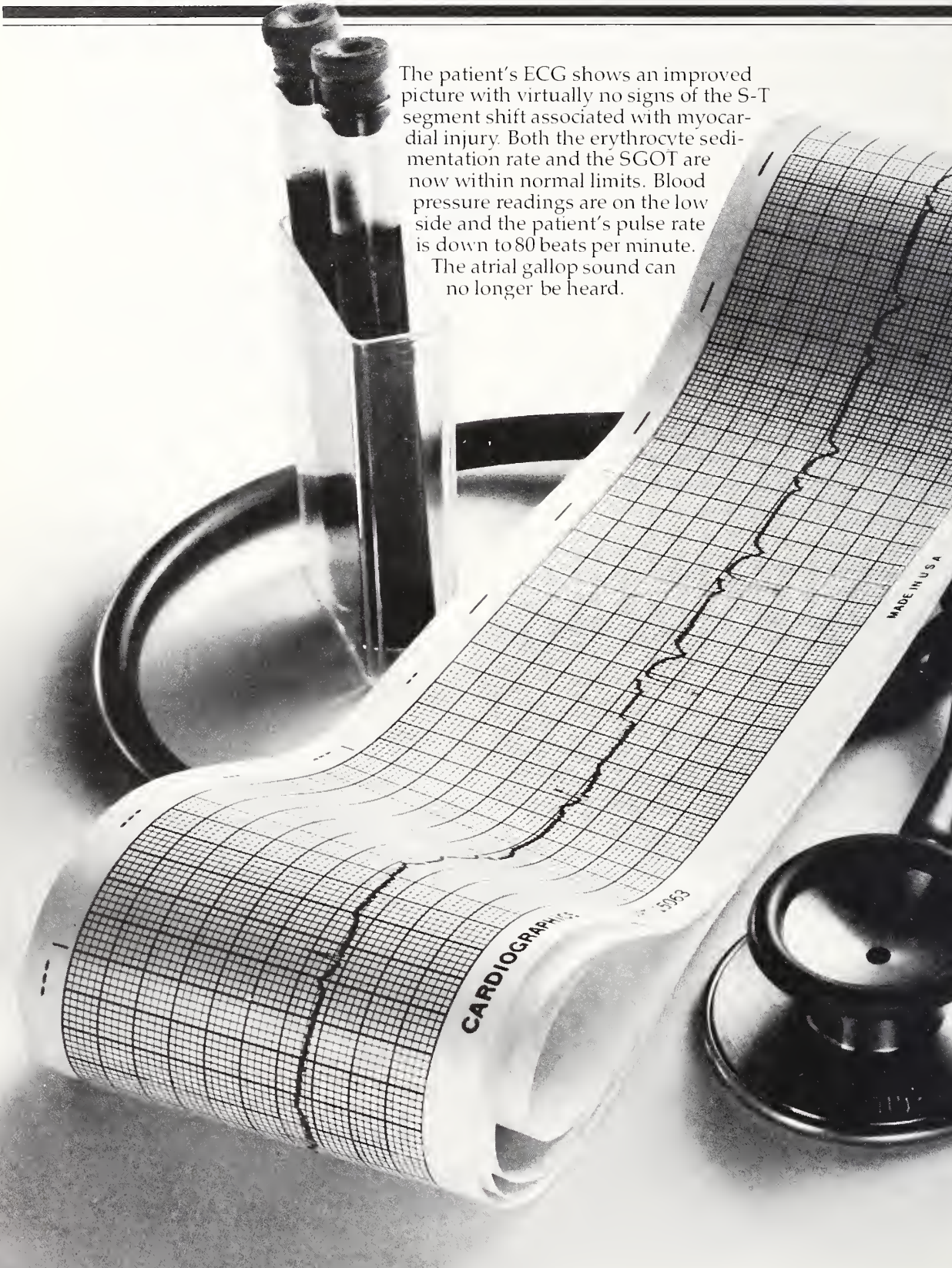


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IN THE ANXIOUS POST-MI PATIENT

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The patient's ECG shows an improved picture with virtually no signs of the S-T segment shift associated with myocardial injury. Both the erythrocyte sedimentation rate and the SGOT are now within normal limits. Blood pressure readings are on the low side and the patient's pulse rate is down to 80 beats per minute. The atrial gallop sound can no longer be heard.



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An especially important advantage: Valium (diazepam) is usually well tolerated. Though drowsiness, ataxia and fatigue are encountered with some patients, these and more serious side effects are rarely a problem. Patients who will be taking Valium during their first weeks at home should be cautioned against the simultaneous drinking of alcohol. Periodic reassessment of the patient's need for psychotropic medication is also recommended.

*feelings of tension*  
*difficulty in falling asleep*  
*loss of interest*  
*inability to relax*



# VALIUM<sup>®</sup>

## diazepam/Roche<sup>®</sup>

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TO REDUCE EXCESSIVE ANXIETY  
TO MORE MANAGEABLE LEVELS

Before prescribing, please see following page for a summary of product information.

ROCHE<sup>®</sup>

# VALIUM<sup>®</sup> diazepam/Roche

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Use in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

**Dose:** Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium<sup>®</sup> (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500. Tel-E-Dose<sup>®</sup> packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



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# IMJ

Illinois Medical Journal

Volume 158, No. 5, November 1980

## A Review of 64 Cases

# Hamartoma of the Lungs

BY ELENITA HERNANDEZ, M.D. AND CESAR V. REYES, M.D./HINES

*Hamartomata of the lungs are relatively uncommon. We have reviewed 64 cases, consisting of 42 surgically removed tumors which presented as asymptomatic coin lesion on routine chest radiographs and 22 tumors incidentally found on necropsy. Our clinical and pathologic observations confirm the previously published data. These lesions probably represent a benign neoplastic proliferation of the pulmonary and bronchial connective tissue stroma, exhibiting a preponderant cartilaginous differentiation.*

The term hamartoma, originally coined by Albrecht in 1904, refers to an abnormal, benign proliferation of component organ tissue(s).<sup>1-10</sup> In the lungs, the tumor is composed predominantly of cartilaginous tissue.<sup>1-13</sup> It is usually recognized

as an asymptomatic coin lesion on chest X-ray examination and as an incidental postmortem finding.<sup>1-10</sup> Some authors classify the entity as either the relatively small, circumscribed lesion of adult, or the more diffuse, lobar tumor of newborn and childhood.<sup>2,10</sup> We have studied the clinical and pathologic data in 64 cases of the so-called adult form of pulmonary hamartoma and briefly present our findings.

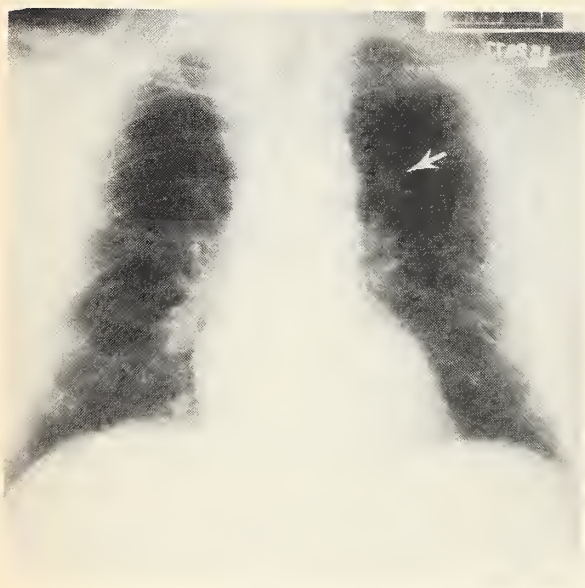
**ELENITA G. HERNANDEZ, M.D.,** was a resident physician in pathology at Hines Veterans Administration Hospital at this writing. Doctor Hernandez, who cites a particular interest in surgical pathology, is a member of the Illinois Registry of Anatomic Pathology.

**CESAR VILLASTIQUI REYES, M.D.,** is a board certified clinical and anatomic pathologist affiliated with the Hines Veterans Administration Hospital. An assistant professor in the department of pathology at the University of Illinois Abraham Lincoln School of Medicine in Chicago, Dr. Reyes is acting chief of the clinical laboratory section at Hines.



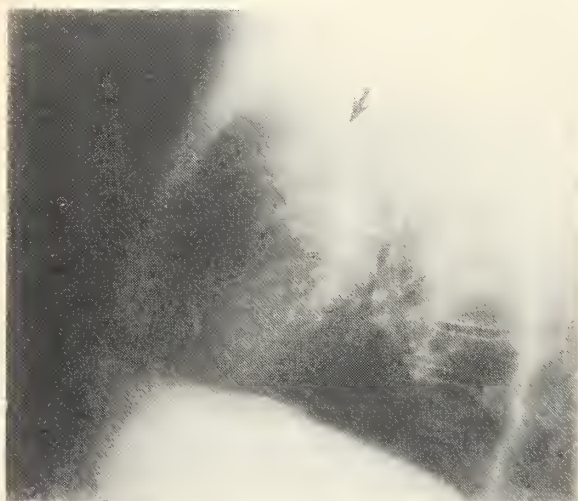
## Materials and Methods

The files of the Tumor Registry and Laboratory Service of Hines VA Medical Center were searched for the listings under hamartoma of the lungs from 1948 to 1978. By the pathologic description of Liebow,<sup>2</sup> Bateson,<sup>8</sup> and Spencer,<sup>10</sup> there were 64 cases indexed. These included 22 incidental lesions isolated out of 18,077 autopsies and 42 surgically removed tumors. The review of the hematoxylin-eosin stained sections were supplemented by gross specimens, photographs, available roentgen films and clinical charts. Other cases in which fibrous, leiomyomatous and epi-



**Figure 1**

An anteroposterior view of chest roentgenogram showing a small, solitary hamartoma (arrow) in the right upper lobe of lung.



**Figure 2**

A lateral view roentgenogram of Figure 1.

thelial elements histologically dominate the tumor tissue were excluded.



**Figure 3**

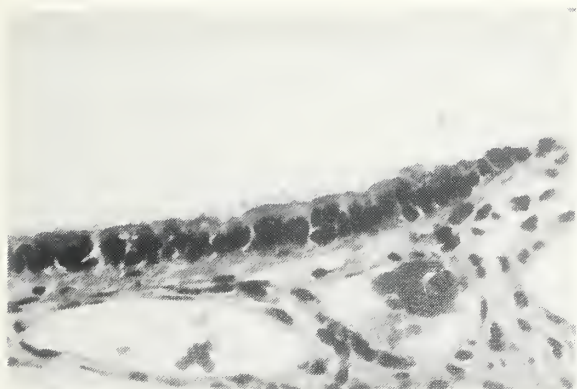
A representative micrograph demonstrating a mature hyaline cartilage and epithelial-lined cleft and cystic spaces. Hemotoxylin-eosin.

### Clinical Features

The ages of the patients ranged from 23 to 83 years with a mean age of 57 years. Men were almost exclusively affected. Caucasians predominated, approximately six times more than blacks. All cases were asymptomatic. Forty two tumors were first discovered as a coin lesion(s) on routine chest X-ray screening. Twenty-two instances were incidentally found on necropsy.

Radiographically, the lesion appeared as a well circumscribed, round, solitary nodule underneath the pleura in the peripheral, inter-fissural and hilar lung fields. They usually demonstrated a clear and distinct margin without surrounding infiltrate (Figures 1 and 2). Calcification, accentuated on laminography, was occasionally observed. Two cases presented with two concurrent lesions in the same lobe.





**Figure 4**

A close up of the epithelial cellular elements of a pulmonary hamartoma. Hematoxylin-eosin.

A frozen section examination during exploratory thoracotomy was utilized in diagnosis of the majority of the clinically identified 42 cases. The procedure was commonly followed by a simple enucleation or a wedge resection of the tumor. Three patients had segmentectomy. Another three cases had lobectomy, two of which were hilar and bronchial lesions, respectively.

### Pathologic Findings

The tumors were most often well demarcated with a pseudocapsule of compressed fibrous and lung tissue around. They were firm to hard and exhibited irregular, lobulated, sometimes pearly, outer surfaces. Cut sections displayed a homogeneous, greyish white cartilaginous tissue. Their sizes varied from one to five centimeters with an average of 2.5 cm.

Microscopically, a nodular, mature hyaline cartilage composed the major part of the tumor tissue. The chondrocytes were uniform, almost invariably single per lacuna and properly spaced (although focal aggregation was present). The epithelial cellular elements were also prominent and closely resembled a respiratory type of epithelium lining slit-like clefts, small cystic formations, and ducts as well as glands in, between and around the cartilage (Figure 3). The epithelium was frequently made up of a single layer of flat, cuboidal to tall, focally ciliated, columnar cell (Figure 4). These epithelial structures were usually supported by loose, fibrous and fibro-myxomatous stroma. In addition, varying amounts of smooth muscle, adipose tissue, medium-sized and dilated small veins and capil-



**Figure 5**

The hyaline matrix, benign chondrocytes, lymphoid cell collection and few fat cells are emphasized, Hematoxylin-eosin.

laries, calcification, mononuclear cells, lymphoid cell collection, and plasma cells were observed (Figure 5). Rare bone spicules were noted. There was no evidence of atypical and malignant neoplastic change.

### Location

As shown in Table 1, the right upper lobe accounted for 18 hamartomata. Subpleural and peripheral locations were striking in the majority of cases. Two hilar and one bronchial tumor were recorded. Two instances showed two lesions simultaneously in the same lobe. The examples with unspecified sites were all postmortem findings.

### Discussion

The clinical and pathologic data in 64 cases of the adult form of hamartomata of the lungs

**Table 1**  
**Summary of the Lobar Distribution**  
**In 64 Cases of Hamartoma of the Lungs.**

Right upper lobe	18 cases
Right lower lobe	15 cases
Left upper lobe	6 cases
Left lower lobe	6 cases
Middle lobe	4 cases
Hilar location	2 cases
Bronchial location	1 case
Not specified	12 cases
<b>TOTAL</b>	<b>64 cases</b>

encountered at our institution during a period of 31 years are presented. Our results confirm previous reports.<sup>1-13</sup>

The tumors are usually small and subpleural. The patients are often male Caucasians in their fifties or sixties. The hamartomata are initially detected as an asymptomatic coin lesion on routine chest X-ray. One-third of cases in our series are incidental postmortem findings. The diagnosis is readily established during exploratory thoracotomy with a frozen section examination. The latter not only discounts differential considerations of a primary or metastatic carcinoma and infectious granulomatous diseases but also frequently dictates operative procedure. A simple enucleation or wedge excision is the mode of treatment. A wider resectional approach, either segmentectomy or lobectomy, may be indicated for the hilar, bronchial and large tumors.

The incidence of pulmonary hamartomata has been variously stated as 0.25% of the general population,<sup>6,11</sup> one of every 400 individuals,<sup>2</sup> from 0.027 to 0.25% of autopsy series,<sup>1,4</sup> six percent of surgically resected coin lesion,<sup>14</sup> and 0.19% of patients subjected to thoracotomy for lung neoplasms.<sup>11</sup> The apparent rarity and multifarious reporting of the incidence perhaps can be explained on the asymptomatic nature and small dimension of the tumors; therefore, many lesions miss detection.

Similarly, the long list of synonyms used to describe these lesions, including chondroadenoma, chondromatous hamartoma, bronchial mixed tumor, etc.,<sup>2,10</sup> attests to their uncertain histogenesis. The latter embraces the following: (1) malformation or overgrowth of a displaced bronchial anlage; (2) neoplasm of the bronchial connective tissue; (3) mixed tumor of the bronchus and (4) proliferative reaction to inflammatory process.<sup>2,8,12</sup> We concur with the view<sup>8,12</sup> that hamartomata of the lungs constitute a benign

neoplasm of the pulmonary and bronchial connective tissue stroma.

There are several unusual features of pulmonary hamartomata, namely: massive size, multiplicity, atypical and malignant neoplastic changes, tumor enlargement on radiographic follow up, and clinical manifestation.<sup>1-11</sup> Two hilar and one bronchial lesion are of note in our series.

By electron microscopy, the epithelial cellular component is compared to the lining of distal bronchioles and type two pneumocytes. The sub-epithelial stromal cells are akin to fibroblasts and primitive glycogen-rich cells; the deeper stromal cells exhibit chondroid features.<sup>12</sup> Intranuclear tubular bodies are also occasionally seen, the significance of which is not clear.<sup>13</sup> ◀

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# Renal Metastatic Epistaxis

## Case Report and Update of Literature, 1966-1978.

BY MAHENDRAKUMAR PATEL, M.D., RAMAKRISHNAN THINAKKAL, M.D.,  
BURTON SOBOROFF, M.D., AND ROBERT BORKENHAGEN, M.D., D.D.S./  
MAYWOOD AND HINES

*This study adds an additional case to the published reports of renal cell carcinoma metastatic to the nose. Bernstein, et al, collected forty cases of renal metastases to the maxilla, nose and paranasal sinuses from 1905 to 1966. From reports published in the following twelve years (1966-1978), the present authors have collected five more cases, including one described in the text below.*

*The nasal lesion preceded discovery of primary tumor in the kidney in more than half the communications. Epistaxis was the presenting sign in 70% of patients with renal metastases to the nose and sinuses.*

Upper respiratory infection, trauma, hypertension, hormonal, allergic and other causes commonly represent the first category for diagnostic

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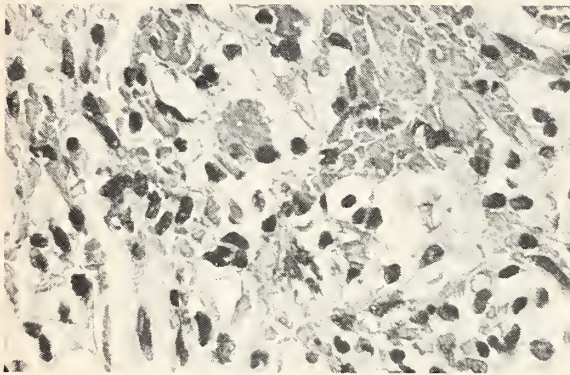
consideration of epistaxis. Less common is the primary neoplasm. Often the tumor is not diagnosed initially, since the demands of controlling epistaxis come first. Maxillary and ethmoid malignancies are obvious examples of tumors characterized by bleeding, but requiring special radiographic and other studies for accurate diagnosis.

Far less common as a cause of nasal bleeding is the metastatic lesion in the sinonasal tract. Despite the infrequency of such metastatic lesions, one should be aware that in half the cases of nosebleed from an obscure metastatic lesion, the primary tumor develops in the kidney. Search for a primary lesion ought to be directed to the renal system early in evaluation.

### Case Report

A 61-year-old white male was seen in the Otolaryngology Clinic of the Veterans Administration Hospital, Hines, Illinois, complaining of intermittent slight bleeding from the left side of the nose for approximately two weeks. Examination showed a small fleshy mass beneath the left middle turbinate, with a scant amount of blood in the area. The remainder of the ear, nose and throat examination was negative. Paranasal sinus X-rays showed a polyp or cyst in the right maxillary sinus (the side opposite to the bleeding). Blood count, chest X-ray and SMA 12 were normal. The electrocardiogram was normal.

There was a history of adult onset diabetes controlled by diet. A history of diverticulitis and three transient episodes of left arm paresis related to a right cerebral artery infarction was obtained.



**Figure 1**

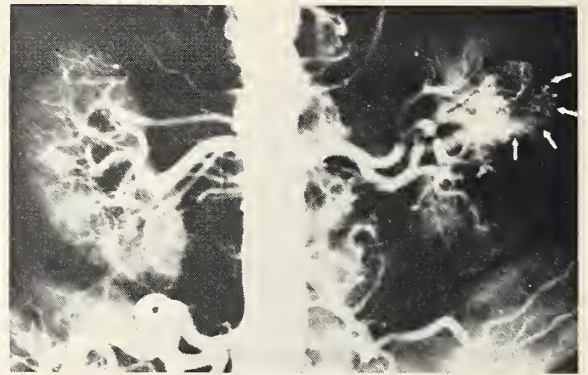
High power view of renal cell metastasis to nose from region of left middle turbinate. Note the typical large round cells with clear, vacuolated cytoplasm.

He was treated with methyldopa and hydrochlor-thiazide for moderate hypertension. Anticoagulants had previously been used during the self limiting paresis, but this medication had not been given for many months prior to the nasal bleeding. No complaints of hematuria or flank pain had been present.

Biopsy of a 1x1.5cm nasal mass one month later through a lateral rhinotomy approach in the operating suite was interpreted as "adencarcinoma, probably from kidney." Study directed toward the kidney showed a negative microscopic urinalysis and pyelogram. A whole body gallium scan three weeks after rhinotomy was normal, but a CAT scan directed toward the kidney showed a 3cm solid mass in the right kidney. Infusion nephrotomography had shown an irregular area in the midzone of the right kidney interpreted as small cysts and probable scarring. Renal angiogram was interpreted as showing a "well circumscribed hypervascular mass in the middle third of the right kidney." A week after the gallium scan, a right nephrectomy was performed. The histologic sections confirmed a renal clear cell carcinoma as the primary tumor.

One month following nephrectomy, a resection of the left middle and inferior turbinate and lateral wall of the nose was accomplished through a rhinotomy approach. A left sublabial antrotomy was also performed. A small hemorrhagic remnant of tumor 5x3x3mm arising from the anterior lateral wall of the middle turbinate was found. Postoperative healing was uneventful.

Microscopic sections from the nose demonstrated a compressed epithelium of columnar and squamous type. The submucosa was formed of



**Figure 2**

Angiogram in the arterial phase shows rounded mass in superior pole of right kidney, representing increased vascularization of renal tumor with dye uptake. Microscopic urinalysis, pyelogram and nephrotomogram failed to aid in diagnosis of renal cell carcinoma.



**Figure 3**

Venous phase of arterial angiogram as seen in Figure 2, showing persistence of dye in the renal tumor.

tumor showing glandular structure with clear and vacuolated cytoplasm of the cells. Well formed, fairly uniform nuclei were seen. Some showed prominent nucleoli with variation in size



and shape. The tumor was hemorrhagic with congested and dilated blood vessels. The kidney tumor showed similar characteristics.

### Comment

**Occurrence**—Renal cell carcinoma (hypernephroma) occurs most frequently in the fifth or sixth decade, and has slightly higher incidence in the male than female. It is the most common tumor to metastasize to the nose and paranasal sinuses. The metastatic lesion is discovered in 50-60% of cases before the primary lesion in the kidney is discovered.<sup>1</sup> This was the finding in the present case study. Where the lesion was in the nose and sinuses, 70% presented as epistaxis.<sup>2</sup>

It may occur many years after treatment for primary renal carcinoma. Eneroth described a 58-year-old male who presented with renal metastatic tumor in the antrum 13 years following nephrectomy.<sup>3</sup> Schantz described a 72-year-old female presenting with epistaxis secondary to nasal metastasis of a renal tumor 20 years after a nephrectomy.<sup>4</sup> Walter and Gillespie described a metastatic renal cell metastasis of 50 years' duration.<sup>5</sup>

Kidney metastases may spread to any part of the body. Lung, liver, regional lymph nodes and skeletal system are the most common sites. Solitary kidney metastases have been observed in every body system, including gall bladder, tongue, eye, adrenal, mandible, breast, thyroid, atrio-ventricular node, urogenital ridge and multiple cutaneous regions. An overall incidence of 1-3% has been estimated for solitary metastases.<sup>6</sup>

### Review of Literature

In 1966 Bernstein, *et al.*,<sup>7</sup> published an extensive report on metastatic disease to the maxilla, nose and paranasal sinuses. The primary site was in kidney, breast, urogenital ridge, gastrointestinal tract, pancreas, adrenal and skin melanoma. Of 82 cases described, 40 were metastatic from the kidney. This communication confines itself to the kidney and adds five more cases from the world literature, 1966 to 1978.

In 1968 Schuknecht<sup>8</sup> described 10 cases of kidney metastases to the ear. Braun-Falco and Lukacs (1971) listed a metastasis to the nasal tip and vestibule.<sup>9</sup> Miyamoto and Helmus (1973)<sup>10</sup> grouped six reports of metastatic renal tumors to the head and neck. Schantz, *et. al.* (1976) reported three cases of metastasis to the head and neck, each of which had co-existing pulmonary lesions.

In 1971, Boles and Cerny<sup>11</sup> wrote on 16 cases

from their institution, and stated that of the overall 1-3% incidence, 15.2% were metastases to the head and neck. In a review of 30 cases of documented renal adenocarcinoma between 1975-1978 from the Veterans Administration Hospital, Hines, Illinois, only one case of solitary head and neck metastasis with nephrectomy for the primary lesion was found.

Dermatological literature records numerous instances of cutaneous renal metastasis. In 1977, Takino, *et al.*, described a frontal involvement among fourteen skin cases.<sup>12</sup> An unusual metastatic involvement was described in 1978 when a bilateral tonsil renal metastasis was reported.<sup>13</sup>

### Pathogenesis

Approximately 83% of renal tumors are adenocarcinoma. Distant blood borne metastases may develop in any area. The reason for this wide distribution is that the renal carcinoma invades the rich vascular network within the kidney by direct extension into the arcuate, lobular, interlobular and renal veins. A rich venous anastomosis with the plexus of prevertebral, vertebral and epidural system has been described.<sup>14</sup> Veins without valves offer little resistance to propagation of tumor emboli. As the intraabdominal and intrathoracic pressure is increased there is a retrograde flow from the usual venous channels back through the prevertebral and vertebral veins which may extend up as far as the base of the skull. The pterygoid plexus, cavernous sinus and pharyngeal plexus communicate with the vertebral system and easily transport the embolus to the region of the nose and sinuses. Regional lymph nodes in the renal pedicle and periaortic areas, connecting to the thoracic duct and then to the systemic circulation, are another route of metastasis.<sup>2</sup> The caval and portal circulation also provides a path to the gastrointestinal tract.<sup>15</sup>

### Diagnosis

Final diagnosis of renal cell metastasis is made by surgery. In a vascular tumor of the nose or sinuses, the metastatic tumor is most common. Histologically, the classic appearance of kidney malignancy is that of clear, large, rounded and vacuolated cells. Numerous variations exist, however, and accordingly the initial diagnosis may be doubtful. According to Miyamoto, thyroid is the most common site of metastatic renal cell carcinoma in the head and neck. It is very difficult to differentiate histologically between primary adenocarcinoma of the thyroid and parathyroid and metastatic renal tumor in these glands. Biopsy is best done in the operating suite with the patient

**Table 1**  
**RENAL CARCINOMA METASTASES**  
**UPDATE OF REPORTED CASES, 1966-1978<sup>1</sup>**

**MAXILLA, NOSE, PARANASAL SINUSES:**

<i>Author</i>	<i>Age</i>	<i>Sex</i>	<i>Presenting Symptoms</i>	<i>Site of Metastasis</i>	<i>Treatment</i>
Braun-Falco, Lukacs (1971) <sup>2</sup>	70	M	Nasal mass, epistaxis	Nasal tip and vestibule	Diathermy, Radiation, Chemotherapy
Boles, Cerny (1971) <sup>3</sup>	55	M	Massive nasal bleeding	Nasal tip	Unknown
Boles, Cerny	62	M	Epistaxis	Ethmoid Sinus	Unknown
Miyamoto, Helmus (1973) <sup>4</sup>	53	F	Neck pain, Dysphagia, facial paresthesia, submucosal nasopharynx mass	Base of skull, upper vertebral bodies	None
Shantz, Miller, Graham (1976) <sup>5</sup>	70	F	Epistaxis	Middle Turbinate	3000 Rads (2 weeks)
Patel, Thinakkal, Soboroff, Borkenhagen (1978) <sup>2</sup>	61	M	Epistaxis	Middle Turbinate	Surgical Excision

1. Comprehensive review 1905-1966 by Bernstein, *et al.* Forty cases collected, five of which were original reports involving maxilla, nose, paranasal sinuses.
2. Single case reported.
3. Total 16 cases, including tip of nose (1), suprascapular (1), occipital cutaneous (1), neck (3), mandible (1), supraclavicular (1), larynx, neck, cheek (1), parietal lobe (1), ethmoid (1), thyroid (1), brain (1), scalp-skull-clavicle (1), cervical spine (1), frontal bone (1).
4. Total six cases including ear (1), nasopharynx (1), occipital (2), larynx (1), tongue (1), temporal lobe and supraclavicular (1).
5. Total three cases, including parotid-pulmonary (1), middle turbinate-pulmonary (1), orbital-maxillary-pulmonary (1).

prepared for major surgery, since these tumors tend to bleed profusely.

If there has been a previous nephrectomy, comparison with original slides is useful. In the occult solitary metastasis a search of the renal system by urinalysis (70% of renal tumors have hematuria), intravenous pyelogram, CAT scan and angiogram are required. In the smaller tumors the lesion may not easily be determined. This was true in the present study, where the urinalysis, pyelogram and nephrotomogram were negative.

#### **Treatment**

The patient with solitary renal metastasis has about a 35% prospect for surviving five years after aggressive treatment. Likelihood of further metastasis is high.

Solitary metastasis is well treated by wide excision in the head and neck area. The choice for surgery depends on the general condition of the patient, resectability limitations of the area invaded, and the presence of other metastases.

Palliative radiotherapy and chemotherapy may be used as primary or adjunctive modes.

An interesting note on the management of the case presented was that biopsy of a pedunculated fibrous middle turbinate lesion resulted in minimal bleeding, contrary to the usual finding. Secondary resection of the lateral wall of the nasal cavity was accomplished without excessive blood loss. ◀

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## EXCELLENT FACULTY, FINEST HOTEL PEAK OF WINTER SEASON

# The Obfuscation of Nurses, Physician Assistants and Other Personnel As Physician Extenders

BY MARSHALL W. McLEOD, Ed.D.  
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*There is growing interest regarding training and employment of so-called physician extenders. There is particular interest in employment of such personnel to alleviate physician shortages and physician maldistribution, as envisioned by federal and regional health planners.*

The term *physician extender*, suggests a person other than a licensed physician, who by some means extends the physician's capacity to provide health care. The term has no definite functional or legal meaning. It is no more specific than such terms as paramedic, associated, allied, ancillary or supportive health personnel. It is principally associated with two specific occupations, physician assisting and nurse practitioner practice, but is not limited to those.

As science broadened the scope and effectiveness of modern health care, new functions initially assumed by physicians soon branched into specialized occupational fields with specialized technical and professional personnel. Two examples are radiology and the medical laboratory sciences. When diagnostic and therapeutic aspects of radiation and chemical analysis were discovered, physicians exclusively took X-rays and made chemical tests. Increasing complexity and utilization later made it necessary for technicians and specialized professionals to be trained to augment what was originally the physician's purview. This was to be repeated over and again,

and continues today as the myriad of health care workers continues to grow. Each occupation, as it attains specific education and definite licensure, certification or registration, tends to develop stratification with respect to level of occupational function. Each in its own way tends to extend the capacities of the physician and other health care workers. The process has caused a highly complex system of interdependent health care workers to evolve; some working under the direct supervision of physicians and others working independently of physicians.

This paper seeks brief examination of a few types of personnel in order to aid in differentiating several categories and abilities that tend to be confused. These major categories of physician extenders are: (1) Nurse practitioners and related nurse specialists; (2) Physician assistants and related specialists; (3) Medical office assistants and (4) Emergency service personnel.

Particular attention will be given to the situation in the State of Illinois with regard to legal sanction.

## Nurse Practitioners

Every state in the Union under law provides for two general types of licensed nursing personnel: the registered nurse (R.N.) and the licensed practical nurse (L.P.N.).

The licensed practical nurse has training of such level that he or she must function directly and only under the supervision of licensed health personnel such as a medical doctor, dentist, or registered nurse. In many employment situations the licensed practical nurse in fact extends physician capacities by undertaking certain functions at physician direction.

The registered nurse, on the other hand, may have had technical training in a hospital diploma program, or in a community college associate degree program (A.D.N.). Baccalaureate (B.S.N.), or professional nurse education for the registered nurse, is based upon a four year program of liber-

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al arts, science and nursing education, leading to what is usually termed a generic program. By whatever means of education, the registered nurse possesses the legal capacity to practice in a wide variety of roles, depending upon the employment function.

The nursing profession is presently in the process of evolution regarding functional levels of registered nurse education and practice. In the viewpoint of the American Nurses' Association (A.N.A.), technical nursing practice for registered nurses is beginning to emerge as that level represented by diploma, and A.D.N. education. The field of professional nursing is emerging, albeit with some confusion, based upon baccalaureate and master's degree preparation. There is much confusion regarding capabilities of various types of nurses. This issue, although not considered herein, is further confused by the fact that all types of registered nurses are licensed under the same law. Hopefully, the licensure for technical and professional nurses will be separate in the future. In 1974, the Congress for Nursing Practice of the American Nurses' Association defined professional nursing as follows:

*Practitioners of professional nursing are registered nurses who provide direct care to clients utilizing the nursing process in arriving at decisions. They work in a collegial and collaborative relationship with other health professionals to determine health care needs and assume responsibility for nursing care needs and assume responsibility for nursing care. In the course of their practice they assess the effectiveness of actions taken, identify and carry out systemic investigations of clinical problems, and engage in periodic review of their own contributions to health care and those of their professional peers.<sup>1</sup>*

Three levels of professional registered nurse practice were defined by the Congress: nurse practitioners, nurse clinicians and clinical nurse specialists.<sup>2</sup> In addition, there are nurse midwives and nurses in independent practice.

### Nurse Practitioners

*Nurse Practitioners have advanced skills in the assessment of the physical and psychological health-illness status of individuals, families or groups in a variety of settings through health and development history taking and physical examination. They are prepared for these special skills by formal continuing education which adheres to A.N.A. approved guidelines, or in a baccalaureate nursing program.<sup>3</sup>*

We assume that nurse practitioner training must

be in conformity to state nurse training and practice acts; that continuing education training is extensive and that baccalaureate education has specialized components beyond those of the basic generic program. Many nurse practitioner programs are now at the master's degree level.

### Nurse Clinicians

*Nurse clinicians have well-developed competencies in utilizing a broad range of cues. These cues are used for prescribing and implementing both direct and indirect nursing care and for articulating nursing therapies with other planned therapies. Nurse clinicians demonstrate expertise in nursing practice and insure ongoing development of expertise through clinical experience and continuing education. Generally minimal preparation for this role is the baccalaureate degree.<sup>4</sup>*

### Clinical Nurse Specialists

*Clinical nurse specialists are primarily clinicians with a degree of knowledge, skill and competence in a specialized area of nursing. These are made directly available to the public through the provision of nursing care to clients and indirectly through guidance and planning of care with other nursing personnel. Clinical nurse specialists hold a master's degree in nursing preferably with an emphasis in clinical nursing.<sup>5</sup>*

Clinical nurse specialists are becoming essential in the care of the hospitalized patient. They work intensely with patients and families who need assistance in adjustment to loss and/or illness, treatment, and/or hospitalization. He or she teaches the staff as well as the patient and family.

### Nurse Midwives

Nurse midwives have long been known in Europe as providers of care to "normal" pregnant women. They provide pre- and postnatal care and deliver the child. Nurse midwives are increasingly popular in this country. A nurse midwife requires special certification, and usually has a master's degree in midwifery. The nurse midwife and the lay midwife are dissimilar and have different preparations: the nurse midwife obtains his or her education and introduction to practice in a college or university setting after receiving a baccalaureate degree, the lay midwife learns procedures in an apprenticeship situation and has no formal education or clinical training. There is much concern regarding the lay midwives' ability to provide for the quality of health care necessary for

pregnant women. In February, 1979, a bill was introduced in the Illinois legislature that would create a new midwifery practice act, providing for both lay and nurse midwives. The Illinois Nurses Association presented a position paper criticizing the bill on the basis that it did not insure safe care settings, or uniformly qualified professionals.<sup>6</sup>

Terminology tends to be clouded by the various titles given for specific nurse education programs. There appear to be few, if any, specialized programs at the baccalaureate level. However, there are many certificate non-degree and many master's level programs.

Examples of certificate programs which require a registered nurse license are Pediatric Nurse Practitioner, Family Nurse Practitioner, Pediatric Nurse Associate, Medical Health Evaluation Nurse Specialist, Ob-Gyn Nurse Practitioner, Adult Health Care Practitioner, Rural Health Care Nurse, and Nurse-Midwife.<sup>7</sup>

Examples of master's degree programs (all of which require the registered nurse license, a baccalaureate degree and usually job experience) are: Cardiovascular Nurse Clinician, Community Health Nurse Practitioner, Maternal Nurse Practitioner, Adult Nurse Specialist, Child Nurse Specialist, Psychiatric-Mental Health Nurse Clinician, Nurse-Midwife, and Family Nurse Practitioner.<sup>8</sup>

Examples of doctoral degrees (all of which require the professional nursing license, baccalaureate degree, master's degree, experience and research) are Ph.D., D.N.Sc. and D.S.N.

State nursing codes tend to skirt the explicit scope and depth of such nursing practice. In theory, the nurse practitioner is legally able to act either with or without direct physician supervision; though there tends to be delimitation, if murky, with respect to independent practice. For example; the Illinois Nursing Act states that, " 'Registered Nurse' or 'Registered Professional Nurse' means a person who is registered under this Act and practices professional nursing as defined in paragraph 1 of this Section."<sup>10</sup> That paragraph reads as follows:

*"Professional nursing" means the performance for compensation of any nursing act (a) in the observation care and counsel of the ill, injured or infirm; or (b) in the maintenance of health or prevention of illness of others; or (c) the administration of medications and treatments as prescribed by a licensed physician or dentist; or (d) any act in the supervision or teaching of nursing; and of which requires substantial specialized judgment and skill and the proper per-*

*formance of which is based on knowledge and application of the principles of biological, physical and social science acquired by means of a completed course in an approved school of professional nursing. The foregoing shall not be deemed to include those acts of medical diagnosis or prescription of therapeutic or corrective measures which are properly performed only by physicians licensed in the State of Illinois.*<sup>11</sup>

Attempts in recent years to make the last sentence of the definition more permissive have been unsuccessful.

Registered nursing in expanded roles is still in evolution. Nurses with special training may, within the provisions of the particular state's nurse training and practice act, engage in health care practice independently, in the practice of nursing or a clinical nursing specialty.

### Physician Assistants

Registered nurses and licensed practical nurses have for many years assisted physicians in many ways, including performing physician functions under the supervision of the physician—in effect acting as physician extenders. Only recently has a new health occupation, the physician assistant, (P.A.) evolved. Even though many are still in effect serving the physician in a subservient role, the nursing profession desires to move toward independent practice roles for many of its members. It is not the intent of this paper to examine the independent practice of nursing. However, nurses have developed independent practices like health consultation, community health nursing, women's health clinics, counseling dying people and families, and in mental health. As modern nursing has evolved over this century, the physician's assistant has emerged only during the last two decades.

In 1970, the Board of Medicine of the National Academy of Sciences<sup>12</sup> formulated definitions which categorized the three principal types of physician's assistants.

*Type A:* The Type A assistant is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other, more technical assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the im-



mediate surveillance of the physician. He is, thus, distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgement.

*Type B:* The Type B assistant, while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in one clinical specialty or, more commonly, in certain procedures within such a specialty. In his area of specialty, he has a degree of skill beyond that normally possessed by physicians who are not engaged in the specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action. An example of this type of assistant might be one who is highly skilled in the physician's functions associated with a renal dialysis unit and who is capable of performing these functions as required.

*Type C:* The Type C assistant is capable of performing a variety of tasks over the whole range of medical care under the supervision of a physician, although he does not possess the level of medical knowledge to integrate and interpret findings. He is similar to a Type A assistant in the number of areas in which he can perform but he cannot exercise the degree of independent synthesis and judgement of which Type A is capable. This type of assistant would be to medicine what the practical nurse is to nursing.<sup>13</sup>

In many situations, the registered nurse employed in a physician's office, hospital and other setting has, in fact, performed as a Type A physician's assistant. Often orderlies, medical office assistants or nurse aides have served as Type B assistants. And perhaps the most obvious example of Type C service has been provided by military corpsmen and medics. Yet, in each of the three examples listed, none expressly qualify as physicians assistants under state law, (with registered nurses as one temporary exception in Illinois) unless it be Type C.

Illinois law provides for the licensure (certification) of physician's assistants. This law<sup>14</sup> has been in effect since July, 1976. Originally it provided that registered nurses could take the physician's assistant examination for immediate certification without a separate training program, but this was repealed in 1977.<sup>15</sup> In Illinois a physician's assistant is:

... (A)ny person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under the "Medical Practice Act". A physician's assistant may perform such medical procedures

*within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the direct supervision of a physician. Physician's assistants cannot exercise independent judgement for purposes of diagnosis and treatment of patient.*<sup>16</sup>

The law states that the physician's assistant cannot use the title of *doctor* or *associate*. The physician can charge for the services of the physician's assistant, but not the physician's assistant. Each certified physician's assistant must hold valid certification by the National Commission on Certification of Physician's Assistants, be a graduate of an approved P.A. education program and have passed an examination of the Illinois Department of Registration and Education.<sup>17</sup> In Illinois, the physician's assistant is subordinate to the physician rather than an independent practitioner, as is the nurse in certain situations. The physician's assistant in Illinois is required to be a type B or type C category physician's assistant, because the independent diagnostic and therapeutic roles of the category A physician's assistant are restricted by Illinois law. The Illinois Board of Higher Education in a staff paper (1975) stated:

*The Illinois law makes the physician's assistant very dependent on the physician so it is unlikely that Illinois will have soon a "physician's associate" who could provide care semi-independently perhaps at a site remote from the physician. Thus, it is unclear whether the introduction of physician's assistants, of the type defined in the law, would greatly affect care in underserved areas. They might extend the capabilities of physicians presently practicing in these areas. They could not, however, provide care in places where there were no physicians. One kind of professionals that might serve areas presently underserved are nurses educated for an expanded, probably interdependent, role.*<sup>18</sup>

Although there are presently no physician's assistant training programs in Illinois there are many in neighboring states. Currently there are approximately 50 physician's assistant-type programs in the United States which are accredited by the American Medical Association. Current

Table 1

*A recent Illinois survey of physician attitudes regarding physician's assistants resulted in the following summary findings.*

Illinois primary care physicians surveyed indicate fairly divided attitudes toward hiring physician assistants for their own practices. Nearly four-fifths of them, however, favored permitting P.A.'s to assume at least some degree of responsibility for many medical and surgical procedures.

Physicians most positive toward hiring physician assistants were those in larger multi-specialty groups, those under 40 years of age, and those living in the Champaign or Decatur areas.

Pediatricians, solo practitioners, older doctors and those from the East St. Louis area expressed the least positive views towards P.A.'s.

Illinois physicians, in general, do not expect use of a physician assistant to allow them more time away from the office nor to increase the amount of non-office centered health care (e.g., house calls, nursing home visits).

On the other hand, two thirds of the doctors felt that the utilization of a P.A. would increase the number of patients they could care for and nearly half felt that using a P.A. would give the physician increased time for the more complicated cases.

Physicians overwhelmingly believe that the use of a physician assistant would increase their medical liability.

While almost half of the physicians would hire a P.A. who met their qualifications, only 32% would hire one who had a high school diploma and 20 months of training, which are the minimum qualifications established by the Physician Assistant Practice Act.

While, in general, the physicians indicated a willingness to delegate at least some authority for nearly all the medical and surgical tasks included in the survey, the tendency was to delegate more responsibility for those tasks judged less difficult or complex to perform.

The proportions of physicians favoring the concept and use of the physician assistant would undoubtedly have been greater if certain issues, particularly the malpractice liability question and the state requirements for certifications had been clarified or resolved concurrent with the passage of the Physician Assistant Practice Act.<sup>23</sup>

program occupational titles include: Physician's Assistant, Physician's Associate, Clinical Associate, MEDEX<sup>19</sup>, Child Health Associate, Community Health Medic, Psychiatric Assistant.<sup>20</sup>

It is interesting that the U.S.S.R. has perhaps the most (281 *feldsher*) physician assistant-type training programs, the USA second.<sup>21</sup> P.A. titles in some other nations are:

Benin	— <i>Infirmier</i>
Congc	— <i>Assistant Medical</i>
Yemen	— <i>Medical Assistant</i>
Ethiopia	— <i>Health Officer</i>
India	— <i>Junior Health Assistant</i>
Iraq	— <i>Diploma in Sanitation</i>
Turkey	— <i>Siglik Koleji Diplomasi</i>
Uganda	— <i>Medical Assistant</i>
Tanzania	— <i>Rural Medical Aid</i> <sup>22</sup>

It must be recognized that the physician's assistant field is at present evolving and that many significant changes in it must be expected. Some difficulties relative to physician's assistant utilization are only presently beginning to emerge.

Some pioneer university based programs for their training, for various reasons, have been terminated. Problems have been encountered which include: still to be evolved formal and informal relationships between the physician's assistant the the physician and between the physician's assistant and the public; and the apparent variability of student ability and curricula among the various training programs. Further, it is a field which is developing unevenly across the nation with the result that physician's assistant utilization will tend to vary from state-to-state.<sup>24</sup>

### Other Physician Extenders

Other physician extender categories may present some confusion with regard to utilization. This confusion stems from the often overlapping, often ill-defined limits used for such occupational titles as: paramedic, emergency technician, allied health worker, ancillary worker, associated health worker, medical (office) assistant, orderly-aide-assistant. The following sketches are presented for clarification.

*Paramedics*—The terms paramedic and para-



professional are indefinite designations which are slowly going out of usage. Paramedic has been associated with the broad field of allied health worker generally, and with the various types of emergency medical technicians specifically. Paramedics are not physician's assistants, though they may be any of a number of types of emergency service workers. Its usage as a prefix to medical appears to be on the wane.

**Emergency Technicians**—In Illinois there are two principal types of specialized emergency personnel; the mobile intensive care personnel designated as emergency medical technicians-ambulance (E.M.T.-A level I level II). The E.M.T.-A. level I must successfully complete an 81 hour basic training program and pass the National Registry of Emergency Medical Technicians examination. The E.M.T.-A. I is trained to provide basic emergency assistance to victims on-site and in-transport to hospital trauma centers. The E.M.T.-A. level II has advanced training which enables the person under Illinois law to provide extensive on-site aid, including administration of medications and therapy per radioed instructions by trauma center physicians or registered nurses.<sup>24</sup> Emergency medical technicians may be called *paramedics* in some states.

**Allied, Associated, Ancillary Workers**—These are general terms that relate to the technicians, technologists, semi-professionals and professional health care workers who work under the supervision or in concert with physicians, dentists and other health professionals as a part of the total health care system.

**Medical Office Assistants**—Persons with clerical training are frequently employed by physicians and given on-the-job training for performing certain health-related tasks under intensive physician supervision. There are some medical assisting educational programs but most are trained on the job. Such personnel are not licensed although many have certification under the American Association of Medical Assistants.

**Orderly-Aide-Assistants**—Hospitals, clinics, nursing homes and other care centers employ persons to undertake comparatively low-level health care tasks at the direction of registered nurses, medical doctors or other supervisory personnel. These persons usually learn on the job, although there are a few formal training programs. Few states have standards of any form for aide education or proficiency.

As health care becomes more complex more sub-categories of supportive health care workers will evolve. Existing categories of health manpower will change their roles. It is probable that

extenders of physician activity, especially nurse practitioners and physician assistants, will become increasingly important in health care. It remains to be seen in what manner, how fully, and with what degree of independence such personnel will be utilized. However, questions regarding the rights of health care consumers, legal and ethical issues concerning the quality of health care delivery and personnel, and the education of the public to these new roles of expertise of health professionals and semi-professionals, need to be addressed. The issues are much too important to remain clouded much longer. Caution must be exercised in any attempt to alleviate severe physician shortages and maldistributions though the general usage of physician extenders. ◀

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# Pediatric Perplexities

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## Gingival Lesion and Streptococcal Pneumoniae Type 14 Bacteremia

BY ROBERT NUDELMAN, M.D., WILLIAM BENTSON, M.D., SULEKHA POLAVARAPU, M.B., AND RUTH ANDREA SEELER, M.D./CHICAGO

*Although pneumococcal bacteremia is a common infection in infants, the association of pneumococcal bacteremia and a gingival lesion was first reported in 1975, with additional cases noted in 1979.<sup>1,2</sup> We have recently seen a similar patient at the Cook County Children's Hospital which adds further confirmation to the association of a gingival lesion with pneumococcal bacteremia.*

A 14 month old Black male developed a swelling of the left lower eyelid four days prior to admission, fever one day prior to admission and swelling of the left cheek 12 hours prior to admission. The child was premature, birth weight 2240gm, and had hyaline membrane disease,

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*Beta hemolytic streptococcal bacteremia and hyperbilirubinemia in the neonatal period. Subsequently, he had been well, developing normally, and free of infection. On admission, he was irritable, the rectal temperature was 38.8° C., the heart rate was 150/min, and the respiratory rate was 34/min. The height, weight and head circumference indicated good catch-up growth. The left mid cheek was swollen but not indurated, slightly warm, nontender and without erythema or purplish hue. In the region of the unerupted first left upper molar tooth, there was an erythematous and fluctuant appearing mass on the alveolar ridge. The vestibular buccal mucosa opposite this area was also swollen. Two small left submandibular matted nodes were palpable. The rest of the physical exam was unremarkable. The white blood cell count was 13,400/dl with a differential of 54% polymorphonuclear leucocytes and 4% bands (536/cumm). The hemoglobin was 9.7 gm/dl. A radiographic examination of the maxilla revealed impending eruption of the first molar tooth.*

The gingival lesion was incised and a few drops of yellow serous fluid expressed which subsequently yielded a pure culture of *Streptococcus pneumoniae* type 14. A blood culture also grew *Streptococcus pneumoniae* type 14. The patient was initially treated with intravenous penicillin G 100,000 units/kg. He responded dramatically and was afebrile within 12 hours; the gingival lesion



resolved within 24 hours, and the cheek swelling had subsided at 48 hours. After the initial 1½ days of parenteral therapy, he was placed on oral penicillin G and discharged. However, compliance at home was poor, and he was seen the following day with an obvious right upper lobe pneumonia which responded to procaine penicillin.

### Comment

Although the report of gingival lesion with pneumococcal bacteremia appeared in 1975, this was the first patient hospitalized at the Cook County Hospital and recognized to have this association. We have been interested in pneumococcal disease for some time, and it is our feeling that this association is, indeed, quite unusual. It is quite possible that the lesions are being missed on routine physical examination or the infants are being sent home without being admitted.

The pneumococci isolated from our patient was a type 14, the single most common serotype at this institution.<sup>3</sup> In one of the previously reported cases, pneumococci were isolated from the lesion but serotyping was not done. Interestingly, in the previously reported six cases, all have involved the maxillary alveolar ridge; none have been described on the mandibular ridge. Our patient (at 14 months) was somewhat older than the pre-

vious six patients, all of whom were 10 months of age or younger.

Whether this lesion is peculiar to infants rather than older children remains to be determined. Nevertheless, it seems definite that a typical gingival lesion is associated with pneumococcal bacteremia, although the occurrence seems relatively infrequent.

Hopefully, physicians who see a febrile child (greater than 38°C.) who plan to do a CBC and blood culture should make a careful inspection of the maxillary alveolar ridge. Because of the commonness of pneumococcal bacteremia, and the obviousness of the alveolar lesion, it should be fairly easy to determine incidence, age range, and pneumococcal types for this entity. ◀

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# ***Abstracts of Board Actions***

*(Continued from page 319)*

## **HOUSE OF DELEGATES RESOLUTIONS**

At its annual meeting, the House of Delegates referred several resolutions to the Board for study and report back. Acting on those proposals, the Board voted to recommend that the House reject:

- Res. 80A-2 which calls upon ISMS to adopt the AMA's model state statute defining death and seek its enactment in Illinois. The Board concluded that current ISMS policy contains an adequate definition of death . . . and that determining death is a clinical diagnosis which is part of the practice of medicine and, therefore, should not be "statutized".
- Res. 80A-5 which calls upon ISMS to inform the Illinois Health Facilities Planning Board (IHFPB) that the Society "disapproves of the current (IHFPB) policy of planning for the past; and . . . offer its expertise in developing methodology for utilization of past experience to develop future need projections in health planning." Discussions with IHFPB officials revealed that the resolution's intent is being addressed in current IHFPB review procedures.
- Res. 80A-18 which directs ISMS to work toward modification of IDPH rules on mandated phenylketonuria (PKU) and T-4 testing including deletion of requirements that direct hospitals to send samples to state laboratories for processing. Since introduction of the resolution, legislation was passed which requires that all samples be sent to state labs, regardless of the hospital laboratory's proficiency.

The Board will introduce resolutions at next month's House session urging the House of Delegates to:

- Authorize ISMS to offer and support legislation that would amend all Illinois insurance laws so that all coverage—including that for physician services in health insurance policies—would be offered as options, with selection resting solely with the policyholder. This is viewed as a possible long-term solution to the continuing fight—viewed by legislators as a "turf battle"—over mandated inclusion in health policies of various professions. In effect, the proposal would force each profession to rise or fall on its own merits, since policyholders would pay additional premiums for each coverage option.
- Delete from the ISMS Policy Manual the statement titled "Osteopaths, Association With" . . . and to amend existing policies titled: "Blood Procurement," "Laboratories," and "Hospital Records and Their Availability."
- Amend the bylaws to require that resolutions submitted by the ISMS Student Business Section and Resident Physicians Section must meet the same deadline requirements as other resolutions to qualify for House consideration.

## **LEGISLATION**

ISMS will urge Gov. Thompson to use his amendatory veto power to make several changes in legislation designed to revamp IDPH's Emergency Medical Services (EMS) system. The bill requires IDPH to maintain a statewide EMS program and grants IDPH authority to license and regulate ambulances . . . but exempts any ambulances maintained or operated by a unit of local government—the majority of ambulances in Illinois. In addition, it apparently grants the Emergency Medical Services Advisory Council veto power over the state EMS plan. ISMS will urge the governor to: (1) Specify that the EMS Advisory Council has the right to review, but not veto, the state EMS plan; and (2) Remove the exemption for ambulances operated by units of government from inspection . . . or remove requirements that any ambulance be inspected.



## **CME/ICCME**

The Board approved an increase in CME accreditation fees effective January 1. The new fees will be: \$500 for physician organizations of 49 or fewer members; and \$750 for all other applicants.

The Society will provide basic funding for ICCME during 1981 in the same manner as this year, including half (\$10) of each dues-paying member's AMA-ERF contribution plus additional support from general funds sufficient to support current staffing (two professionals, two or three administrative/secretarial assistants) plus necessary office space and related costs. Total financial support will be based upon needs as determined by the ISMS Finance Committee

## **WORKMEN'S COMPENSATION**

Presidents of Illinois specialty societies will be asked to provide names of physicians willing to serve on impartial testimony panels that would be called upon to help resolve disputed Workmen's Compensation cases. Recently-enacted legislation calls upon ISMS to organize the panel system. Initially, the societies will be asked to submit the names of two physicians from each ISMS Trustee District who, preferably, are board certified, endorsed by the county medical society and hold ISMS membership.

## **ALLIED HEALTH PRACTITIONERS**

Following an analysis of the nurse shortage problem in Illinois, the Board voted to actively promote the current ISMS policy which supports all types and levels of nurse education . . . and support the concept of career ladder opportunity in the nursing profession. ISMS will encourage retention and expansion of diploma nurse education programs by voicing its support for: (1) Program accreditation by the Board of Higher Education and North Central Association of Colleges and Secondary Schools; (2) Expanded financial aid from state and other agencies; and (3) Recognition of the high quality care provided by diploma school graduates.

ISMS will officially protest IDPH's practice of developing and promulgating "guidelines" for hospital pilot programs that involve credentialing of non-physician health care personnel. The Society will point out that the guidelines: (1) Conflict with licensure laws and regulations; and (2) Circumvent the rulemaking process and the Administrative Procedures Act.

## **IDPA DRUG MANUAL**

The following drugs were approved for inclusion in the IDPA Drug Manual: Gaviscon Liquid Antacid, Estrovis (Quinestrol), Ponstel (Mefenamic Acid), and Tri-Hemic 600.

## **SPECIAL PROGRAMS**

Acting on requests concerning special programs, the Board voted to:

- Co-sponsor an AMA-produced negotiations training program in conjunction with a 1981 House of Delegates meeting if scheduling permits. Registration fee for the program—which would offer Category 1 CME credit—would be \$150.
- Co-sponsor—with IDPH and Ill. Society of Microbiology—a workshop on "Imported Infections in the Era of the Refugee," November 19-20, at the Holiday Inn, Elmhurst.
- Hold a reception for new members of the General Assembly, February 18, in Springfield.
- Join with the Ill. CPA Society to develop a program on topics of interest to physicians, CPAs and other professionals. Possible subjects include: computers for the small office, trusts, MMIS, and buying vs. leasing offices.
- Schedule a half-day leadership conference during the 1981 ISMS annual meeting on the topic of "Competition Through Alternative Delivery Systems."
- Authorize the ISMS Resident Physicians Section to hold a two-day seminar in January or February on "Establishing Yourself in Practice." The program—conducted by Conomikes Associates, Inc.—will be held at ISMS headquarters.
- Discontinue ISMS co-sponsorship of the Illinois Nutrition Committee's Annual Nutrition Conference.

ISMS will urge the St. Clair County Medical Society to support the U.S. Dept. of Defense's Civilian-Military Contingency Hospital System (CMCHS) and ask that the society encourage local

hospitals to cooperate with the Air Force in this project. CMCHS is designed to accommodate treatment of casualties arising as a result of possible, future military conflict between the U.S. and a foreign power. An important aspect of the program is to make prior arrangements for assistance from civilian physicians and health care facilities which could temporarily supplement the capabilities of the military health care system. The CMCHS concept—endorsed by AMA and American Hospital Assn.—initially will be employed in the Scott Air Force Base Medical Center area which includes St. Clair County.

#### APPOINTMENTS/NOMINATIONS

ISMS will nominate the following physicians for appointment to IDPA's Medical Quality Review Committee which makes peer review recommendations, testifies at hearings and participates in audits and special projects: *Drs. Robert Dooley*, Oak Brook; *Donald Hanscom*, Hinsdale; and *John Harrod*, *Bertram Moss*, and *Milagros Puray*, all of Chicago.

*Dr. Ronald Albrecht*, Chicago, was named the ISMS representative to Technical Advisory Group to the Task Force on State Health Planning of the Ill. Health Facilities Planning Board . . . and *Dr. Lawrence Hirsch*, Chicago, was nominated for appointment to an IDPH ad hoc committee to examine the feasibility of developing an Ill. Health Service Corps.

ISMS will submit to IDPA the names of 18 physicians willing to perform peer review under contract with IDPA. Last spring, IDPA agreed to incorporate medical judgment into the Medicaid audit process. Under a pilot program—to be conducted on a limited basis to ensure smooth implementation—physicians audited by IDPA will have the right to have physicians peer review audit determinations concerning the level of care reflected in patient records.

ISMS will nominate the following for AMA awards: (1) Distinguished Service Award—*Dr. Walter Palmer*, an internationally-known gastroenterologist, who for many years served on the faculty of the University of Chicago Pritzker School of Medicine; and (2) Citation of a Layman—*Mr. Foster McGaw*, founder and former president of American Hospital Supply Corp., who has made substantial contributions to several Illinois medical schools and medically-related causes nationwide. ◀

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# Medical Examination for Marriage

*The following is a verbatim reprint of Chapter 40, Section 204, of the Illinois Revised Statutes. Section 204 of the Marriage and Dissolution Act, entitled "Medical Examination," details physician responsibilities in signing health certificates for marriage. A number of inquiries have prompted this reprint, which is provided as a service to the membership.*

## 204. Medical examination

The required medical examination shall include a test to determine the existence of or freedom from syphilis. Such test shall be administered by a duly licensed physician to all persons making application for a license to marry at any time within 15 days prior to such application. Except as provided in Section 205, it shall be unlawful for the county clerk of any county to issue a license to marry to any person who fails to present for filing with such county clerk a certificate signed by such physician setting forth that such person to the proposed marriage is free from syphilis as nearly as can be determined by an examination and such standard laboratory tests as are necessary. If the attending physician finds no evidence of syphilis, he shall issue a certificate to that effect, which certificate shall read as follows:

I, (Name of Physician) . . . . . being a physician, legally licensed to practice in the State of . . . . . do certify that I did on the . . . . . day of . . . . . 19 . . . make an examination of . . . . . and considered the result of an approved serological test for syphilis, which was made at my request, and believe . . . . . to be free from all syphilis.

.....  
Signature of Physician

.....  
Signature of Person Examined

Such certificate of negative findings with a copy of the laboratory report attached thereto as to each of the parties shall be filed with the county clerk of the county wherein the marriage is to be solemnized at the time application is made for a license to marry. Laboratory tests for syphilis required hereunder shall be tests approved by the State Department of Public Health and shall be made by laboratories of the Department or by such other laboratories as are approved by the Department. Such tests as may be made by the health departments of cities, villages and

incorporated towns maintaining laboratories shall be free of charge. The required examination shall also include:

A test for sickle cell anemia to all persons examined under this Act, if the examining physician determines such a test to be necessary. The examining physician shall issue a certificate stating that the test was or was not given and shall record the results. In the case of sickle cell testing, all positive results shall be filed with the examining physician and the Department of Public Health.

*Amended by P.A. 81-934, § 3, eff. Sept. 22, 1979.*

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# EKG

(Continued from page 318)

**Answers: 1. A. B. 2. B.**

This patient had a routine twelve lead ECG taken five years earlier for insurance purposes which showed complete right bundle branch block and marked left axis deviation or left anterior hemiblock. The lead  $V_1$  rhythm strip here shows the prolonged QRS with an  $RSR^1$  of complete right bundle branch block. In addition, sinus rhythm is present with a pattern of 3:2 and 2:1 AV block. The PR intervals are all normal and equal. This is type II second degree AV block (Mobitz). Approximately 2/3 of the patients with Mobitz second degree AV block will have a widened QRS. The majority of these patients have

conduction disease located in the His-Purkinje system or the bundle branches. The ECG that demonstrates complete right bundle branch block and left anterior hemiblock precedes complete AV block in 70 to 80% of the cases. The progression to complete AV block in these patients occurs at a rate of 4 to 6% per year. Intermittent complete AV block was strongly suspected in this patient. A twenty-four hour ambulatory ECG (Holter) was ordered. The tracings demonstrated long periods of complete AV block associated with her symptoms of lightheadedness. A permanent demand pacemaker was placed transvenously in the right ventricular apex. This eliminated her complaint of intermittent lightheadedness. ◀

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# Viewbox

(Continued from page 320)

## DIAGNOSIS: ABSCESS

All of the choices may mimic an abscess. A diagnosis cannot be made on the basis of the images alone. The clinical setting favors the diagnosis of abscess, however, and patient III has a gas containing mass which strongly favors abscess.

Untreated abdominal abscesses continue to be a major problem with high mortality. Currently, post operative abscesses have overshadowed other causes, especially in the upper abdomen. Signs and symptoms may be muted because of antibiotic therapy, which is so widely used. Diagnosis may be difficult.

The diagnosis of abdominal abscess can be suggested on plain radiographs in up to one-half of patients. The primary finding is gas located outside of the bowel. It is often necessary to do a barium enema or upper GI to determine gas collections are truly extraluminal. Findings are often subtle and difficult to evaluate.<sup>1,2</sup> Abdominal imaging with ultrasonography, computed tomography, and gallium-67 now allow the diagnosis of almost all abdominal abscesses. In addition, ultrasound and especially computed tomography can precisely define the location of an abscess.

No prospective study has compared the efficacy of these three modalities but retrospective studies have indicated a degree of accuracy ranging from 80-98% for each modality and up to 100% accuracy when two or three are used in conjunction.<sup>3,4</sup> Identification of a mass as an abscess often requires more than one imaging method.<sup>1,5</sup>

Patients who have no localizing signs and are suspected of having an abscess can be screened with Gallium-67 which has the advantage of viewing the entire body (Figure 1).

Disadvantages of Gallium-67 include a 24-48 hour delay prior to interpretation, difficulty in differentiating foci of activity in normal structures from pathologic localization of the isotope, and non-specificity. False positive studies are more frequent than false negative studies. Gallium-67 localizes in both neoplastic and inflammatory tissue. While the isotope is quite sensitive for inflammatory processes, localized

areas of increased uptake may be due to a number of causes of inflammation in addition to abscess. After positive gallium screening the abnormal areas should be further studied with ultrasound or computed tomography to specifically identify an abscess cavity and its precise location.

If a patient suspected of having an abscess does have localizing signs, the first study would be ultrasound or computed tomographic examination of the area in question. At our institution the whole abdomen would then be scanned in order to identify any additional abscesses. The identification of a cystic mass is not specific for abscess and the diagnosis must be made in light of clinical findings. Gallium-67 scanning is helpful in indicating the inflammatory nature of a mass and needle aspiration can provide a positive diagnosis prior to treatment in problem cases.

Ultrasound has the advantages of speed, less expense, and no radiation exposure. Examination may be difficult or impossible in post operative patients when incisions, drains, ostomies, and dressings prevent access to the skin surface. Bowel gas may also prevent imaging, especially in the anterior pararenal space in patients suspected of having a pancreatic abscess and in the mid abdomen.<sup>5,6</sup> Abscesses containing large amounts of gas may be mistaken for distended gas containing bowel.

An abscess ranges in appearance from an apparent solid mass to a thin walled cyst, depending on its age. Most are sonolucent fluid collections with irregular walls but they may contain some internal echos (Figure 2). Acoustic shadows indicate gas. Other fluid collections such as hematoma, urinoma, lymphocele, cyst, or necrotic neoplasm may have an identical appearance. Gallium-67 can be used to limit diagnostic possibilities to neoplasm or inflammation. Equivocal findings can usually be resolved with C.T.

Computed tomography identifies an abscess as a mass density displacing or obliterating normal anatomic structures. (Artifacts caused by surgical clips may make the examination difficult or even impossible.) With contrast enhancement, a rim of vascular tissue is often identified. As in the case of ultrasound the findings are not specific for abscess with the exception of cases in which gas is identified in the mass (Figure 3).

When there is doubt concerning the nature of a mass, Gallium, ultrasound, and computed tomography have been found to give complementary information. In patients in which the diagnosis remains in doubt, despite multiple studies, needle aspiration with ultrasound or

computed tomography guidance can give a definite diagnosis. An increasing number of patients have been reported in whom large caliber indwelling catheters have been introduced percutaneously to provide drainage and thus avoid surgery.<sup>6,7</sup> ◀

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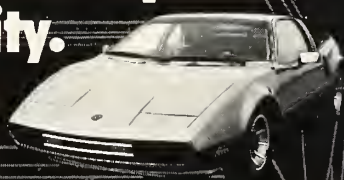
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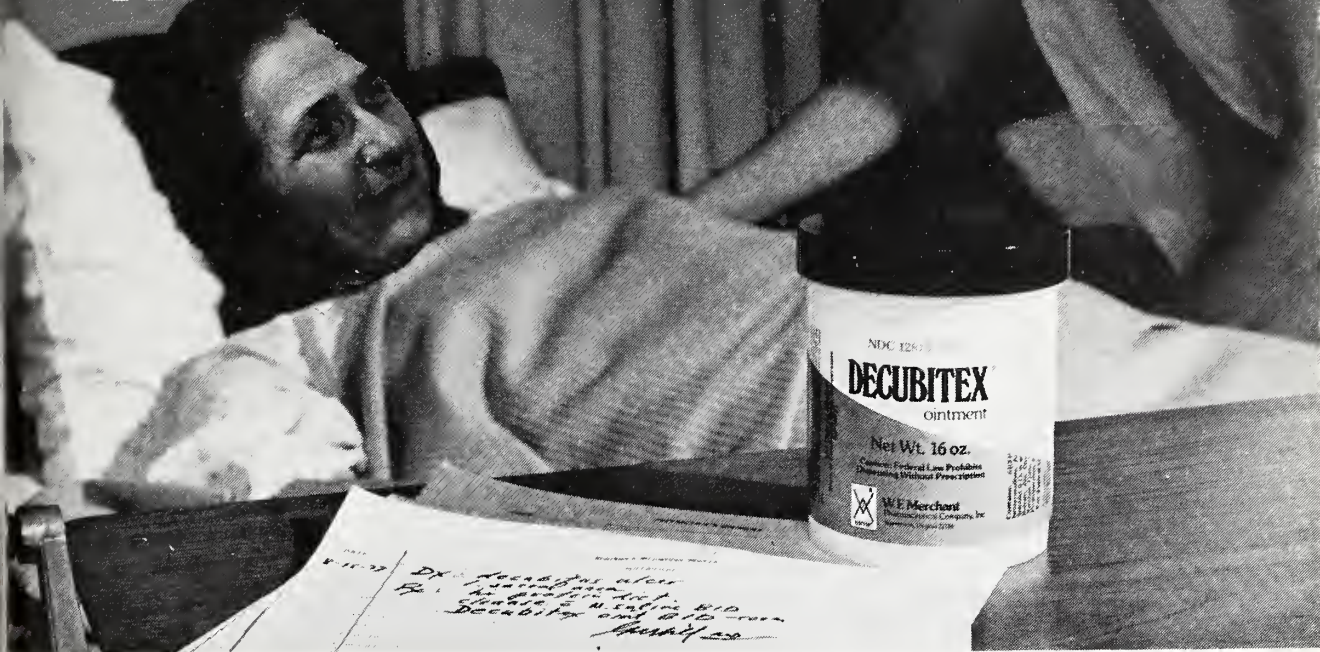
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# Case Reports

## Carotenemia-A Caveat

By SAM J. SUGAR M.D./EVANSTON

*Yellowish pigmentation of the skin (xanthoderma) is most commonly caused by jaundice. However, ingestion of foods high in pigment content resulting from seasonal variations in diet can cause clinical phenomena that can be puzzling unless a careful dietary history is obtained.*

A 40-year-old white male accountant presented for evaluation of "jaundice". For several weeks he had noticed a gradually appearing yellow discoloration of his palms and soles and nasolabial folds. He had no associated symptoms. His only medication was a colchicine-probenecid combination for control of gout. Examination confirmed the yellowish discoloration in the areas described by the patient and revealed no other abnormalities. He denied the ingestion of carrots or exposure to any dyes, but he recalled that for four months he and his wife had been consuming 170 grams of canned pumpkin nightly as a dessert, because of its low price. The wife was subsequently examined and had similar physical findings.

Laboratory tests revealed normal finds for glucose, electrolytes, thyroxine, bilirubin, liver function and lipids. Serum carotene was elevated to 503mcg/dl in the husband and to 406mcg/dl in the wife (normal 50-225mcg/dl). Vitamin A level in the husband was elevated to 142ug/dl (normal 20-80). The abnormality

cleared after cessation of pumpkin intake.

### Comment

Carotene is present in large amounts in yellow and orange vegetables as well as in butter, eggs, oranges, vegetable oils and leafy green vegetables. Up to 30% of the total adult Vitamin A requirement can be provided by Beta Carotene. Daily requirements of 4-5000 I.U. of Vitamin A, contained in 3000mcg of Beta Carotene, can be supplied by ingestion of 58 grams of canned pumpkin daily.<sup>2</sup>

Carotenemia and carotenosis can be caused by a defect in conversion of Carotene to Vitamin A due to myxedema or Diabetes Mellitus, but is usually due to excessive ingestion of foods high in Beta Carotene content. The skin discoloration of carotenosis can be differentiated from that of icterus by the absence of conjunctival and sublingual involvement, due to the increased deposition of pigment only in heavily cornified skin and sebaceous glands but not in mucous membranes. The absence of liver function abnormalities and systemic illness is confirmatory. Cessation of

intake usually results in clearing of the abnormality in several weeks.<sup>3</sup>

While the overt manifestations of carotenemia are primarily dermatologic and not associated with toxic symptoms, recent studies have shown an association between abnormal Carotene blood level and squamous cell carcinoma of the oropharynx.<sup>4</sup> Also, chronic hypervitaminosis A from carotenemia has been associated with hepatic toxicity.<sup>5</sup> Patients should be warned of the potential danger of carotenemia and urged to modify their diets accordingly.

A meticulous dietary history with special attention to the possible ingestion of foods high in Beta Carotene content should be obtained in all patients presenting with apparent icterus or xanthoderma, especially in the autumn months when pumpkins are inexpensive and plentiful as a result of Halloween demand. ◀

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**SAM J. SUGAR, M.D.**, is a board certified internist affiliated with Evanston Hospital in that suburb. Director of medical education at Glenbrook Hospital and associate professor of medicine for the Northwestern University School of Medicine, Dr. Sugar has served as director of health services for the Hebrew Theological College. A member of the ISMS House of Delegates, Dr. Sugar has also served on the ISMS Medical-Legal Council.



# LUPUS FACTS FOR YOUR PATIENTS

Lupus is the subject of a new Arthritis Foundation educational campaign.

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We urge your participation in this effort. Our new fact-filled lupus brochure, written for the layman, covers such subjects as what is lupus, the diagnosis of lupus, who gets lupus, the pattern of lupus, signs and symptoms, a management/treatment program and prevention guidelines. Simply order the desired quantities from your local Arthritis Foundation Chapter office, or write "Lupus," Arthritis Foundation, 3400 Peachtree Road, NE, Atlanta, Georgia 30326.

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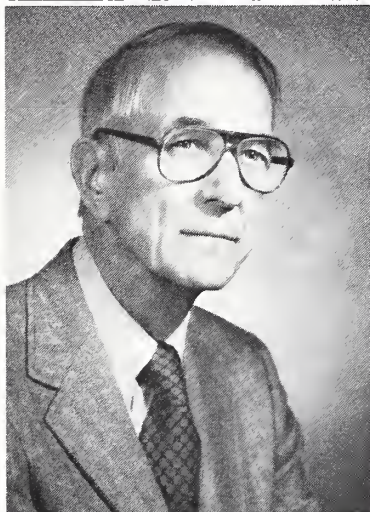
**WHO'S AFRAID  
OF THE BIG, BAD  
LUPUS?**



**YOU ARE.  
WHEN YOU  
KNOW  
WHAT IT  
MEANS.**



# President's Page



**An Idea For The 80's:**

## Civilian Military Contingency Hospital System

At a recent briefing in St. Louis, Air Force Surgeon General Paul Meyer compared past and present U.S. military preparedness, and presented morbidity and mortality statistics from wars dating back to World War I.

This set the stage for a discussion of the Civilian Military Contingency Hospital System (CMCHS), a plan to treat in this country casualties of a major conflict outside the U.S. If a war involving the U.S. broke out anywhere in the world, we could expect to immediately receive a large number of casualties.

The Department of Defense is planning to use civilian hospitals to augment their bed capacity. The contingency plan asks civilian hospitals to commit 50,000 beds to the CMCHS within the next two years. The present federal health system could be enlarged to meet the potential need, but only at great expense and waste of tax dollars. A "mothballed" federal medical system would require a tremendous initial investment, constant monitoring and periodic replacement of equipment and supplies. For these reasons, the CMCHS approach was developed.

The initial program is being instituted at Scott Air Force Base in southern Illinois. Written agreements will be executed with hospitals which can be reached within two hours by helicopter or 50 miles by ground transportation. Still to be resolved are multiple problems, including financing and transportation of casualties.

ISMS endorses this program as a major contribution to our nation's medical preparedness. ◀

A handwritten signature in cursive script that reads "Herschel Browns MD".

Herschel Browns, M.D., President



# Doctor's News

## **ROBERT T. FOX, M.D. RECEIVES VOLUNTARY EFFORT AWARD**—Robert T. Fox,



M.D., Glenview, was recently given a special award for his services as vice chairman of the Illinois State Cost Containment Committee, Illinois Voluntary Effort. Shown in photo at left, Sister Rita Meagher, R.S.M., president, Mercy Center for Health Care Services, Aurora, and past chairperson of the Illinois Hospital Association Board of Directors, presents plaque to Dr. Fox.

The Illinois Hospital Association award cited Dr. Fox's "knowledge, reputation, energy and contribution for leadership of the Voluntary Effort and for many other contributions to the health care field."

The Illinois Voluntary Effort, Sr. Meagher noted, has brought together hospital management, governing boards and medical staffs in a joint effort "to keep operating expenditures and capital budgets at the lowest level on a continuing basis consistent with sound medical practice." That goal, she added, was met by over 90% of Illinois hospitals. Further, Sr. Meagher noted, the November, 1979, defeat of federal cost containment legislation in the U.S. House of Representatives "was a direct result of the success of the Voluntary Effort."

Doctor Fox, former chairman, ISMS Board of Trustees, is a former chairman of the Illinois State Medical Insurance Services Board of Directors and a board certified thoracic and general surgeon. He will continue his work as a member of the ISMS Task Force on Cost Effectiveness and Vice-Chairman of the Illinois State Cost Containment Committee.

**TAMPON USE GUIDELINES ISSUED**—The American College of Obstetricians and Gynecologists has issued the following recommendations for female patients who use tampons. The guidelines, as reported recently by *AM News*, are as follows: (1) In general, women need not stop using tampons, but it would be prudent to discontinue use of newly developed, super-absorbent tampons until more conclusive research has been conducted. (2) To reduce possible risk of tampon use, a woman should alternate them with sanitary napkins or mini-pads during a given menstrual cycle. (3) When tampons are used, they should be changed at least every 6-8 hours to reduce the risk of infection. (4) If a woman is using tampons and experiences such symptoms as high fever, vomiting, diarrhea or a sunburn-like rash, she should discontinue tampon use and consult her physician at once."

The ACOG statement noted that among the some 300 cases of toxic shock syndrome, an actual cause-and-effect relationship between the syndrome and tampon use has not been definitely established. About 5% of those 300 cases reported to the Center for Disease Control occurred in men. About 5% of those women who experienced the syndrome were not menstruating at the time.

The Food and Drug Administration has proposed a warning label for tampons, noting the association with toxic shock syndrome and describing symptoms. The FDA has invited public comment as to whether a label warning would be adequate or a more detailed pamphlet inside the package is advisable.

**CALL TO INTERNATIONAL PHYSICIANS**—The American College of International Physicians, Inc., has initiated an expanded membership development program. Organized in 1975 as a fellowship for physicians educated in medical schools abroad and in the US who are licensed and practicing in the US, membership is open to all physicians who wish to join colleagues from around the world in a cooperative endeavor to discuss and shape policies for medical education, research, ethics and international health activities. Fellowship information and application forms can be obtained by writing the College at 3030 Lake Avenue, Fort Wayne, Indiana 46805.

**PHYSICIANS IN THE NEWS—Robert Becker, M.D.,** Joliet, has been elected president of the American Association of Professional Standards Review Organizations. The AAPSRO is the national association for PSROs, organizations mandated by federal law to assure appropriate quality and utilization of health care services in the United States.

**James D. Schlenker, M.D.,** Chicago, has been awarded second prize in the Junior/Basic Science category of a scholarship essay contest conducted by the Educational Foundation of the American Society of Plastic and Reconstructive Surgeons.

**Robert J. Freeark, M.D.,** Chicago, has been named president-elect of the American Association for the Surgery of Trauma . . . **Melissa J. Yanover, M.D.,** Chicago was recently awarded the 1980 Norris L. Brookens Award, given annually by the Illinois Society of Internal Medicine to a third year resident physician in honor of the late Dr. Brookens, charter ISIM member and its first president. Dr. Yanover is chief resident, department of medicine at Michael Reese Hospital and Medical Center.

**Jack L. Gibbs, M.D.,** Canton, will serve as chairman of Reference Committee D at the December 7-10 Interim Meeting of the AMA's House of Delegates.

Five Chicago physicians have been named to the City's Senior Citizens Hall of Fame. **Roy R. Grinker, M.D., Abraham F. Lash, M.D., Walter L. Palmer, M.D., Olga Brolnitsky, M.D., and John I. Brewer, M.D.,** will join the group of men and women who have been honored for contribution to the social, cultural, religious, economic, scientific and technological life of the city.

**DATA PROJECT INITIATED—**Physicians may recall that a survey of physician manpower and demographic data was enclosed in their license renewal form last Spring. The Illinois Department of Public Health, Division of Manpower, has commissioned Illinois Cooperative Health Data Systems, Inc., (ICHDS) to conduct a follow-up to that survey.

As compliance with the initial effort was tallied at 62%, ICHDS will soon forward a follow-up survey to Illinois physicians. Physicians are advised that the data will be useful to the profession in identifying manpower needs. Those who receive the follow-up survey are urged to complete and return it to ICHDS. All responses are confidential.

**UPCOMING PPI REGULATIONS—**The AMA Department of Federal Legislation has provided additional information on upcoming Food and Drug Administration regulations for Patient Package Inserts (PPIs).

The FDA published their final rule on September 12, noting the general drugs or drug classes to be effected. It should be noted that the regulations will not be effective with respect to a particular drug until 180 days after publication of notice in the Federal Register applying the final rule to that specific drug or drug class.

The rule delineated the 10 drugs and drug classes for which PPIs will be required during the initial program: ampicillins, benzodiazepines, cimetidine, clofibrate, digoxin, methoxsalen, propoxyphene, phenytoin, thiazides and warfaren. A three-year evaluation will be given these initial entities before the rule is extended to other drugs. The new PPI rule does not change current requirements regarding prescription drugs for which PPIs may already be required pursuant to regulations already in effect. These include estrogenic and progestational drug products, among others.

PPIs will be provided to dispensers by each manufacturer and the PPI text will be included in both the package insert and the Physician Desk Reference. AMA is preparing comments on each of the above-noted guidelines. Interested individuals may request copies of the documents by writing: FDA Commissioner Jere E. Goyan, Ph.D., c/o Hearing Clerk (HFA-305), Food and Drug Administration, Room 4-62, 5600 Fishers Lane, Rockville, MD 20857.



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# REPORT

## FOR *Illinois Physicians*

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### Explanation of Payments Form Discussed

(Note: Because of some misunderstandings that have arisen regarding the announcement of our new Explanation of Payments form, following is a further report on how the new systems works.)

Our Blue Cross and Blue Shield Plan has started using a new form, called the Explanation of Payments, which is designed to complement the familiar Payment Voucher.

The Explanation of Payments form, which was introduced in October, is generated on Fridays and mailed out the following Monday by itself. Information on all claims processed during a period from Friday through Thursday appear on the new form. However,

each Explanation of Payments form may contain claims information associated with one or more Payment Vouchers. It's also possible that because of mailing lags, you may receive one or the other form first.

Because of this, we suggest that you hold the checks attached to the Payment Vouchers until you have an opportunity to cross reference the two documents. You will find that the Explanation of Payments form will contain the check number for each claim processed. That number can be matched with the check number on the Payment Voucher and then cashed. This system should make it much easier for you to keep track of claims payments for our members.

---

### Medical Emergency Under the Auto National Account Program

#### MEDICAL EMERGENCY DEFINITION

A payable medical emergency is a life threatening or disabling condition which requires immediate medical attention or treatment.

#### MEDICAL EMERGENCY CRITERIA

The criteria used to determine the existence of a medical emergency condition and whether benefits would be payable are as follows:

- The condition must be of such a nature that failure to render care and/or treatment at the onset could reasonably result in deterioration to the point of placing the patient's permanent health in jeopardy or causing significant impairment to bodily functions of the patient.
- The criteria for judging a medical emergency will be based on the signs or symptoms shown by the patient as verified by the physician at the time of treat-

ment and *not* on the basis of final diagnosis.

- Prompt care must be secured. A medical emergency will not be considered to exist if medical treatment is not secured within seventy-two (72) hours after the onset of the condition.
- Acute symptoms must occur suddenly and unexpectedly. The symptoms must be sufficiently severe to cause a person to seek medical assistance regardless of the hour of the day or night.
- A chronic condition in which symptoms have existed over a period of time will not qualify for medical emergency consideration. Benefits are payable for chronic conditions if symptoms become acute and require immediate medical assistance as determined by the attending physician.

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**Pre-Admission Testing** allows you to schedule pre-surgical tests in an out-patient setting. It can save in-patient days and hundreds of health care dollars. More and more physicians are recommending Pre-Admission Testing for all elective surgery.

**Encouraging Proper use of the Emergency Department** is another way you can help reduce health care costs. Make sure patients understand that the Emergency Department of a hospital is for use only in *emergencies*—not as a substitute for visits to your office.

**Suggesting a Second Surgical Opinion** if your patient is having second thoughts about elective

surgery is a mighty good way to build his or her confidence in you. Furthermore, it may well determine that a different procedure can be equally effective and less costly.

**Prescribing Generic Drugs** as a substitute for their costly trademarked equivalents is rapidly becoming a habit with the medical fraternity. And a good one. Generic drugs, when available, can make an important difference to the medical expenses of your patients.

For Further Information  
On Any Or All These Programs:

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- ☐ **Pre-Admission Testing**
- ☐ **Medical Emergencies**
- ☐ **Second Opinion**

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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

*Contents of IMJ are listed in the Current Contents/Clinical Practice*

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# President's Page



## An Idea For The 80's

### **A Role For Patients In Cost Containment**

Physicians, hospitals, health insurers and others concerned about health costs are working to check the rate of increase. An integral part of that effort involves educating patients about the nuances of health insurance.

The challenge is to alter the public's perspective. More is not necessarily better. First-dollar coverage is expensive, while a policy with deductible and co-insurance features is, in most cases, adequate and always more economical.

Patients also must be convinced that unnecessary use of medical services—or services rendered in the wrong setting—translates into unnecessary cost. And that cost affects all patients through higher premiums and taxes.

Heightened public awareness is only a partial answer. Illinois insurance laws currently mandate inclusion of various ancillary-type services in Blue Cross/Blue Shield policies. Even the cost-conscious patient has no choice of coverage options. ISMS believes he should.

The Society currently is drafting legislation to modify Illinois insurance laws and grant patients freedom of choice in structuring their health coverage. Under this proposal, all services—including those provided by physicians—would be optional. Each option would add to policy cost, but option selection would rest solely with the policyholder.

This approach makes the patient responsible for policy cost. The likely result is a lower premium. There may be other ramifications, such as open competition among all sorts of "healers"—with all sorts of credentials—offering all sorts of health services. With the threat of anti-trust litigation restricting the profession's ability to oppose non-scientific practitioners, we may be forced to embrace an age-old concept: Let the buyer beware. ◀

A handwritten signature in cursive script that reads "Herschel Browns MD".

Herschel Browns, M.D., President

# Abstracts of Action

October 24-26, 1980

Peoria

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## MEDICAID

The Board received a report that IDPA has proposed a Medicaid payment increase—to take effect January 1—that would raise annual Medicaid payments to physicians by at least \$9.5 million. The Board approved applying the increase as follows:

- Increase maximum payment for *Routine Office Visit (90040)* from \$8 to \$11.
- Increase maximum payment for *Total OB Care with Delivery (59400)* from \$275 to \$375.

## HOSPITAL COST CONTAINMENT

ISMS will participate in a hospital cost containment project that will be financed by Blue Cross/Blue Shield to satisfy an Ill. Department of Insurance ruling that it act to check rising costs before being granted a rate increase. The program will be guided by an 11-member Board of Directors composed of representatives from ISMS, Ill. Hospital Assn. and various state government agencies. The public, not-for-profit project will seek to effect cost containment behavior by hospitals and provide program and/or financial assistance to hospitals for specific cost containment efforts.

## HOSPITAL UR OF PRIVATE PATIENTS

The Board endorsed in principle—subject to review and comment by the Chicago Medical Society—a concurrent hospital UR program in Cook County being developed by the Cook County Private UR Coordinating Council. The Council is composed of three representatives each from the Chicago Foundation for Medical Care (CFMC), insurance carriers and corporations.

The program—actually an expansion of CFMC's functioning review activities—will involve inpatient concurrent review and data collection to ascertain if the large sums of corporate dollars spent for hospital care are being employed in a prudent fashion. The Coordinating Council is scheduling briefing sessions for officers of large Chicago-area corporations and meetings with each hospital in Cook County to solicit participation in the program.

## MEDICAL STAFF BYLAWS

ISMS will distribute to hospital medical staffs a set of guidelines—developed by the Society's legal counsel—designed to help the staffs avoid common problems with formulating bylaws. Because of financial and legal considerations, ISMS will not routinely review medical staff bylaws. However, in special circumstances the Board may authorize legal counsel review—at the expense of the medical staff—if the staff requires assistance with a particular problem.

## FREE-STANDING EMERGENCY ROOMS

ISMS will oppose HB 1539 pending in the General Assembly that would establish licensure for emergency outpatient medical treatment centers. However, the Board:

- Adopted the position that a hospital-affiliated free-standing emergency room—governed by the same administration, trustees, and bylaws as its parent hospital, and sharing a common medical staff—should be considered under the hospital's license and subject to the same quality assurance and certificate-of-need regulations as the hospital.
- Agreed to support the use of free-standing emergency rooms in a local mobile intensive care unit system when the project's medical director believes its utilization will increase the effectiveness of the system.

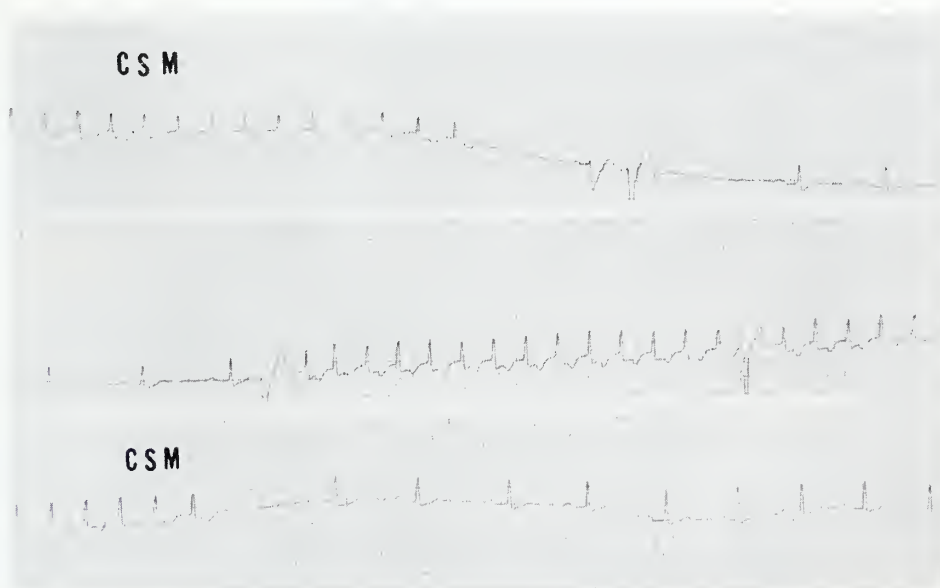
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# EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a sixty-three year old man who initially presented with congestive heart failure due to severe mitral regurgitation. Cardiomegaly and pulmonary hypertension were also present. Open heart surgery with mitral valve replacement was successfully performed. He recovered and did well until the palpitations started. These palpitations would come at unpredictable times and were associated with lightheadedness. No chest pain or dyspnea were caused by palpitations. He had the palpitations the day he came to the clinic. Physical examination confirmed the tachycardia at nearly 170 beats per minute. The opening and closing clicks of the prosthetic valve were quite loud. No ventricular gallop was present and examination of the lungs was normal. This lead II rhythm strip was taken and carotid sinus massage (CSM) was performed.*



## Questions:

1. The lead II ECG rhythm strip shows:
  - A. Paroxysmal supraventricular tachycardia.
  - B. Premature ventricular beats.
  - C. Intermittent sinus rhythm with first degree atrioventricular (AV) block.
  - D. Left atrial enlargement.
  - E. All of the above.
2. Treatment as well as prevention of this tachycardia could include:
  - A. Digitalis.
  - B. Propanolol.
  - C. Carotid sinus massage.
  - D. Phenylephrine or Methoxamine to include an increase in blood pressure.
  - E. All of the above.

(Continued on page 409)

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

**Indications:** Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol<sup>®</sup> Suppositories or Ointment.

**Contraindications:** Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

**Warnings:** The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

**Precautions:** Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

**Dosage and Administration:** Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

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**NOTE:** If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

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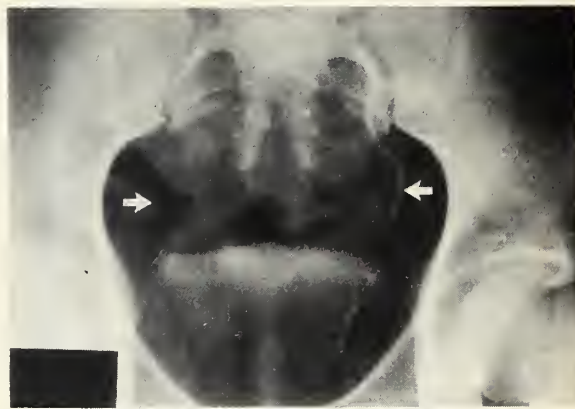
# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This 52-year-old man has a four month history of vague back pain. He has an elevated sedimentation rate.*



**Figure 1**  
—Intravenous urogram, 5 minute film.



**Figure 2**  
—Intravenous urogram. Distal ureters not dilated (arrows).  
The bladder is incompletely filled, but normal.

## Your diagnosis?

1. lymph node metastasis
2. lymphoma
3. pelvic neoplasm
4. bladder outlet obstruction
5. retroperitoneal fibrosis

## Which study would you order next?

1. lymphogram
2. aortogram
3. inferior venacavagram
4. computed tomography
5. ultrasonography

(Continued on page 410)

# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

*At the bottom of all tributes paid to democracy is the little man, walking into the little booth, with a little pencil, making a little cross on a little bit of paper -- no amount of rhetoric or voluminous discussion can possibly diminish the overwhelming importance of the point.*

Winston Churchill

The election recently concluded is considered by many to be a major upheaval within American politics. Whether or not one is pleased with the outcome -- from the presidency to the local school board -- it is clear that the system, our democracy, works.

We sometimes may forget that our democracy is something to cherish and appreciate. In that context, we wish you a peaceful holiday season and a joyous New Year.

P.F. Mahon mo

Chairman

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and one or more will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.



## OBITUARIES

**\*Doroshow, Herbert S.**, Chicago, died October 8, 1980, at the age of 61. Dr. Doroshow was a 1944 graduate of Jefferson Medical College, Thomas Jefferson University.

**\*\*Ellis, James C.**, Rockton, died September 28, 1980, at the age of 81. Dr. Ellis was a 1934 graduate of the University of Illinois School of Medicine.

**\*Grainer, Lorne Sidney**, Arlington Heights, died September 24, 1980, at the age of 50. Dr. Grainer was a 1955 graduate of the University of Toronto.

**\*Heimbach, Aaron, B.**, Blue Island, died October 9, 1980, at the age of 70. Dr. Heimbach was a 1937 graduate of Chicago Medical School.

**\*\*Landmann, Paul Emanuel**, Joliet, died October 3, 1980, at the age of 81. Dr. Landmann was a 1923 graduate of Rush Medical College.

**\*\*Martin, Forest R.**, Decatur, died September 20, 1980, at the age of 78. Dr. Martin was a 1930 graduate of the University of Louisville.

**\*\*Nielsen, Peter M.**, died October 9, 1980, at the age of 87. Dr. Nielsen was a 1932 graduate of the Chicago Medical School.

**\*Petrakos, Harry Nick**, Chicago, died September 30, 1980, at the age of 66.

**\*Rundiks, Steven A.**, Niantic, died September 14, 1980, at the age of 61. Dr. Rundiks was a 1950 graduate of Julius Maximilian University, Germany.

**\*Rusmussen, Collette M.**, Chicago, died June 29, 1980, at the age of 48. Dr. Rusmussen was a 1958 graduate of the University of Chicago.

**\*\*Soukup, John**, Chicago, died September 23, 1980, at the age of 80. Sr. Soukup was a 1925 graduate of the University of Illinois.

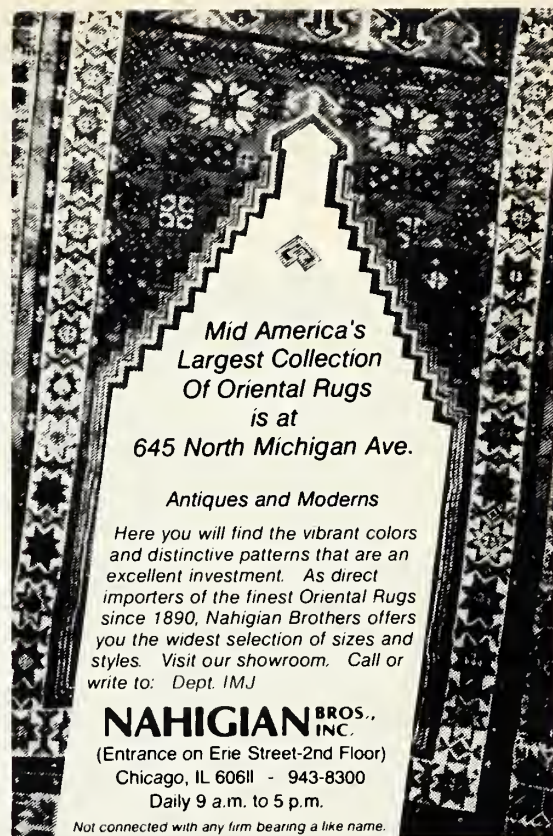
**\*Stenn, Frederick**, Chicago, died October 6, 1980, at the age of 71. Dr. Stenn was a 1933 graduate of Rush Medical College.

**\*\*Wexler, Emanuel J.**, Chicago, died October 13, 1980, at the age of 81. Dr. Wexler was a 1923 graduate of the State University of New York Upstate College of Medicine.

**\*Yamamoto, Fred Juicki**, Lovington, died September 1, 1980, at the age of 74. Dr. Yamamoto was a graduate of Chicago Medical School.

\* Indicates ISMS member

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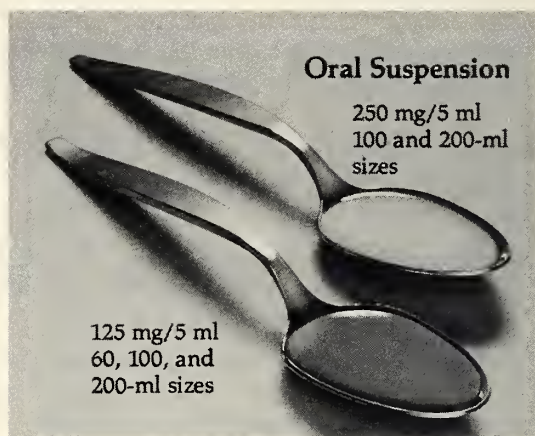
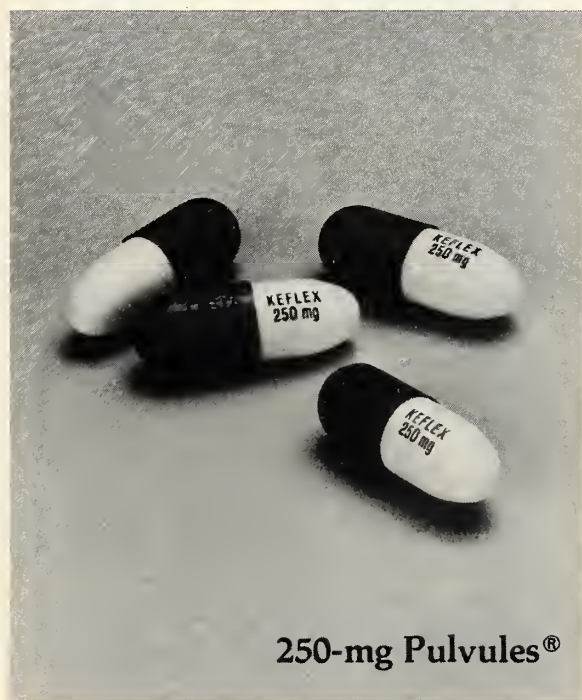
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# IMJ

*Illinois Medical Journal*

Vol. 158, No. 6, December, 1980

## *A Critical Review of 100 Cases*

# Arthroscopy of the Knee

BY HENRY BERNSTEIN, M.D./ELMWOOD PARK

*One hundred consecutive arthroscopic examinations of the knee have been reviewed. The indications, advantages and complications are outlined. Except for viewing the posterior horn of the medial meniscus, which is demonstrated on double contrast arthrography, arthroscopy is the diagnostic tool of preference in knee pathology. This procedure allows the examiner to make a surgical decision with more confidence. Direct vision of meniscal lesions has given rise to a more conservative approach. Early diagnosis of lesions of the articular cartilage has proven valuable.*

In 1918, Kenji Takagi was the first investigator to use a cystoscope to examine the intra-articular portion of a human knee. Problems with light source and sterility delayed the acceptance of endoscopic examination of joints. Since gas sterilization and fibro-optics have solved these problems, the advantages of arthroscopic examination of the knee have become obvious and account for

its introduction and increasingly widespread use in the community.

Much of the knee anatomy, including articular cartilages, menisci, ligaments and fat pad, does not visualize roentgenographically. Intra-articular pathology has remained obscure, subject to definitive diagnosis only by direct vision.

Double contrast arthrography can be helpful in delineating tears of the medial meniscus. The posterior horn of the medial meniscus is usually not seen on arthroscopy unless the examiner uses a second incision in the postero-medial aspect of the joint. Here arthrography has an excellent advantage. However, the lateral compartment of the knee is obscured by a popliteal bursa of variable size which fills with dye. Another limit of arthrography is that it may not tell the surgeon if the meniscal lesion is amenable to surgery, nor does it outline the character of the articular carti-

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**HENRY BERNSTEIN, M.D.**, is a board certified orthopedic surgeon affiliated with Gottlieb Memorial Hospital in Elmwood Park. Dr. Bernstein is a clinical associate in orthopedic surgery at the UI Abraham Lincoln School of Medicine. He is a member of the American Academy of Orthopedic Surgery and the Chicago Orthopedic Society.

Table I  
One Hundred Consecutive  
Arthroscopic Examinations of the Knee

Degenerative deterioration of articular cartilage	26
Surgical lesions of the meniscus	26
Chondral fractures	5
Chrystalline arthritis	2
Non-surgical lesions of the meniscus	11
Miscellaneous	
Chondral fragment	1
Hoffa's Disease—Fibrosis of fat pad	1
Rheumatoid arthritis	1
Attenuated anterior crutiate ligament	1
Post traumatic synovitis	1
No pathology	7
Chondromalacia patella	16
Osteochondritis dessicans	2

lage. Consequently the need for a good diagnostic tool, short of opening the knee for inspection, has been met by the arthroscope.

Arthroscopy can be done as an outpatient procedure, using local anesthesia. The patient is able to resume full activity the next day.

### Materials and Methods

The group studied consists of 100 consecutive arthroscopic examinations performed by the author. The indications for arthroscopic examination were symptoms of intra-articular pathology such as pain, swelling, locking, and giving-way which prevented the patient from engaging in routine activity. If the diagnosis had been sufficiently established to permit rendering medical advice, arthroscopy was omitted. These arthroscopic examinations may be carried out under general anesthesia so that, if indicated, an immediate arthrotomy could be performed. The Wolf® 5 millimeter scope was used and direct vision biopsy equipment was also utilized occasionally to biopsy the synovium or to remove small, loose cartilage fragments. Photography was accomplished using a Pentax® camera with a lens-to-scope adapter, the ACMI 95 light source and Ektachrome® type B film with a shutter speed of 1/60th of a second and F stop of 1.8. The single most important requirement from a technical aspect is sufficient inflation of the knee with a closed system of continuous irrigation. A poorly inflated knee, possibly due to a capsular tear or subcutaneous extravasation of the fluid, rendered examination very difficult.

### Results

The final results are summarized in Table 1. Complications were limited to one case of

thrombophlebitis with pulmonary embolism which responded to anticoagulation. Three examinations proved to be misleading. In one, a fold of fibrotic fat pad was mistaken for a torn meniscus. In another, the medial meniscus angled sharply over the anterior portion of the medial tibial plateau, a normal variant that was thought at the time to represent a tear. A third knee was opened when an attenuated and redundant anterior crutiate ligament was mistaken for a bucket-handle tear of the medial meniscus. There were seven cases in which no pathology was discovered with the arthroscope. Two of these patients, who had normal arthrograms, continued to have symptoms.

Twenty-six knees demonstrated significant enough meniscal disruption to require arthrotomy and meniscectomy. Fourteen of these revealed bucket-handle tears in which only the bucket-handle portion, not the attached peripheral rim, was removed. All of these patients have returned to pre-injury status.

Five knees demonstrated chondral/fractures. Four of these appeared to be traumatic and one was due to subluxing patella. Two knees showed crystalline arthritis. Eleven knees demonstrated lesions of menisci that did not require excision. Ten of these patients have returned to pre-symptom status.

Sixteen patients demonstrated chondromalacia patella (Figure 1). Interestingly, the degree of chondromalacia did not correlate with the pre-operative degree of patello-femoral crepitus. A fluorid, grade III chondromalacia patella might produce no crepitus. However, the stage of the disease did appear to correlate; the long standing yellowish ridging of the undersurface of the patella produced marked crepitus, sometimes when only a small portion of the articular cartilage was involved.

The diagnosis of osteo-chondritis dessicans was



**Figure 1**  
Fluorid, grade III chondromalacia of the patella. Above, the undersurface of the patella demonstrates marked loosening and fibrillation of its articular cartilage. The articular cartilage of the medial femoral condyle lies below.



**Figure 2**  
Chondromalacia of the medial femoral condyle. The uninvolved medial meniscus lies below.



**Figure 3**  
Advanced ulceration of articular cartilage and deterioration of meniscus which lies below and to the left.



made pre-operatively in two knees and the scope used to determine whether the fragment had separated through the articular cartilage. In one knee it had, and an arthrotomy was performed with removal of the fragment. The other patient's articular cartilage was intact and the knee was not opened.

In 26 knees, varying degrees of articular deterioration were observed. The majority of patients who showed articular cartilage degeneration gave no precise history of antecedent injury. Their symptoms, though severe, were insidious in onset and not classically those of osteoarthritis (such as stiffness and pain on initial weight-bearing which improved with walking). Roentgenograms were not diagnostic. These cases probably represent the earliest stages of primary osteoarthritis in which fibrillation of the articular surface is the first pathological event. This may not necessarily lead to osteoarthritis, but may be a benign event, simply representing aging. In these knees a fine, velvety disruption of the articular cartilage and the free edge of the menisci in the weight-bearing portion of one compartment was visualized.

Figure 2 demonstrated degenerative fibrillation of the articular cartilage of the medial femoral condyle. Figure 3 shows degenerative changes of the lateral femoral articular cartilages as well as the lateral meniscus. Whether this will progress to roughening and ulceration remains to be seen. Some of these patients had sustained fractures of the femur or tibial condyles with good bone healing. They continue to exhibit disabling knee symptoms. In this group of post-traumatic cartilage degeneration, secondary osteoarthritis is expected to develop.

## Summary

Review of one hundred consecutive arthroscopies has led to certain observations. The ad-

vantages of scope exam are obvious: unnecessary surgery and consequent morbidity has been sharply reduced. Pre-operative endoscopic exam of the knee also helps to determine which surgical approach is best. Photography proves invaluable in recording intra-articular pathology for medical as well as legal purposes.

Partial meniscectomy, as favored by the author, has gained in popularity. The results have been good though the series is small. Partial meniscectomy results in less post-operative hematoma and shorter hospital stays. Long term followup is necessary to determine if degenerative changes in this group are less than those following total meniscectomy.

Diagnostic arthroscopy of the knee appears to be a safe, reliable and simple means of reaching a definitive diagnosis of intra-articular pathology. Earlier diagnosis of arthritis can be made. Surgery can be eliminated in many meniscal lesions and advice regarding therapeutics given with more confidence. ◀

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# Case Reports

## Monomorphic Adenoma of Lip, Canalicular Variant

BY MARIO STEFANINI, M.D. AND RAFAEL M. DIOKNO, M.D./RICHLANDS, VA.,  
AND DANVILLE

*A case of extrasalivary monomorphic adenoma, canalicular variant is described because of the lesion's rarity and the danger of its confusion with malignant processes.*

Less than 50 cases of canalicular monomorphic adenoma in extra-salivary position have been described.<sup>1</sup> This rare and usually asymptomatic tumor occurs primarily in the older age group and has a proclivity for the upper lip. Another case is added to the limited literature regarding this tumor.

### Case Report

A 54-year-old white man had a history of enucleation of the left eye in 1970 because of malignant melanoma. He was examined because he reported angina on effort. An incidental finding was the presence of a mass, about 0.7cm in diameter, tender, located in the left cheek, close to the upper lip and more readily palpable on the mucosal side. The patient related that the mass had been present for several years. In 1978 the mass seemed slightly larger and was excised surgically under 2% xylocaine anesthesia.

The gross specimen was a bilobed portion of tissue, weighing 0.7gms and measuring 0.7x0.7x0.6 cm, greyish to reddish in color and soft in consistency. Serial sections stained with hematoxylin-eosin showed tubules and columns of



Figure 1  
(Courtesy, Armed  
Forces Institute of  
Pathology)

epithelial cells with shapes from cuboidal to columnar, exhibiting large, ovoid and uniform nuclei with only rare mitotic figures. The

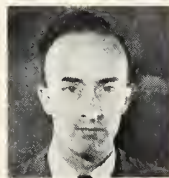
cytoplasm appeared eosinophilic; the stroma between the duct-like cords of parenchymal cells was pale and contained few fibroblasts and inflammatory cells. The entire tumor was encapsulated by a fibrous connective tissue band. The cellular component closely resembled that lining the excretory ducts of the salivary glands.

There has been no evidence of recurrence for the past 18 months.

### Discussion

Since the review by Nelson and Jacoway<sup>1</sup> canalicular monomorphic

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adenomas have been recognized as a distinct entity among the sialoadenomas. From the clinical viewpoint they occur in the older age group, they are consistently benign although they may increase to relatively large sizes. They occur equally in both sexes and they have never been encountered in non-Caucasians. From the histological viewpoint they show a uniform lobular appearance and seem composed of one cell type with no evidence of mesenchymal-like tissue.<sup>2</sup> They can be distinguished from the pleiomorphic adenomas because of the structural arrangement of the epithelial cells and the sharp delineation between epithelium and stroma<sup>3-6</sup> and they can be separated from benign mixed tumors because of the lack of pleiomorphic mesenchymal induction in the stroma. The terms

canalicular, tubular or solid indicate primarily variations of the morphological pattern, although it is not known whether changes in the histological pattern may be accompanied by variation in the clinical behavior.

The major value of the awareness of these tumors is in distinguishing them from malignant tumors (as they have been confused with adenoid basal cell carcinomas, papillary cystadenomas and adenocarcinomas) with potentially disastrous results.

#### Acknowledgment

*The authors wish to thank the personnel of the Armed Forces Institute of Pathology (and especially LTC Edward L. Shaffer, D.C., U.S.A.) for reviewing the histopathological material in this case.*

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# The Illinois Lung Association's First Asthma Camp

BY LANIE E. EAGLETON, M.D./SPRINGFIELD

The Illinois Lung Association sponsored its first Asthma Camp from July 23 through August 5, 1978. The camp was located at Camp Tapawingo near Peoria. The primary objective was to provide a positive camping experience for children who would otherwise be denied this experience because of their asthma. Education was provided to the children on a personal basis. The camp provided a milieu where asthmatic children could develop physically and psychologically while having fun. Fifty-eight asthmatic children, ages seven through 15, attended the camp. Forty-five were from branches and affiliates of the Illinois Lung Association; thirteen campers were from LaRabida Hospital in Chicago. The purpose of this report is to provide the physicians in Illinois (1) a description of the treatment the campers were receiving prior to attending the camp, (2) a description of the special medical care for asthma which was provided at the camp, and (3) information about the availability of a camp for asthmatic children.

Most campers had moderately severe or severe asthma. Forty-five of the 58 campers (78%) were receiving daily maintenance treatment with corticosteroids. An additional 21 campers used steroids for exacerbation of their illness (Table 1). Six of the seven patients who were taking oral corticosteroids were using Prednisone every oth-

**Table 1**  
Table 1 shows the usage of steroids by the campers when they arrived at camp.

	Used Steroids for Exacerbations	Used Steroids During Last 4 Months	Currently Using a Vancril Inhaler	Currently Using Oral Steroids	Currently Using Cromolyn Sodium
45 ILA Branch & Affiliate Campers	28 (62%)	22 (49%)	9 (20%)	2 (4%)	7* (16%)
13 Campers From LaRabida	12 (92%)	11 (85%)	4 (31%)	5 (38%)	10* (77%)
Total of 58 Campers	40 (69%)	33 (57%)	13 (22%)	7 (12%)	17 (29%)

\* 2 of these patients were also using Vancril.

+ 1 of these patients was using Prednisone and Vancril and Cromolyn.

3 others were using Prednisone and Cromolyn sodium; 2 others were using Vancril and Cromolyn sodium.

er day (5 to 30mg). One took Prednisone 5mg daily. Vancril treatments varied from two inhalations b.i.d. to four inhalations q.i.d. Fourteen of the 17 patients who were using sodium cromoglycate used 20mg four times daily.

Thirty-eight of the 58 campers (66%) were receiving treatment with Theophylline (Table 2). Most were receiving this in a single drug preparation. The average dose for patients from the Illinois Lung Association who were treated was probably in the low therapeutic range. Those receiving Theophylline in combination prep-

**Table 2**  
Table 2 shows the amount of Theophylline being used by the campers when they arrived at camp.

	Single Drug Preparation		Combination Drugs with Theophylline	
	Number of Campers	Average Daily Dose	Number of Campers	Average Daily Dose
45 ILA, Branch, and Affiliate Campers	17 (38%)	502 mg.	8 (18%)	452 mg.
13 LaRabida Campers	13 (100%)	1098 mg.	--	--
Total of 58 Campers	30 (52%)	760 mg.	8 (14%)	452 mg.

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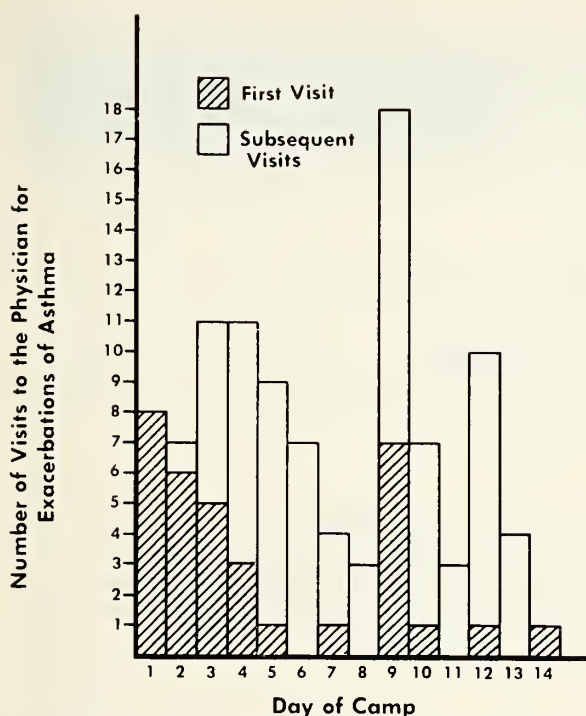


Figure 1

Figure 1 shows the number of visits to the physician for asthma during the camp.

arations were receiving only 50mg per day less than those who were using a single drug preparation.

Sixteen campers (28%) were receiving antihistamines. Nine of these were receiving their antihistamine in a single drug preparation. Twelve campers were receiving oral adrenergic agonists (terbutaline and metaproterenol). Only two used inhalers for a daily medication schedule. Two were receiving iodides.

The camp staff included 12 nurses, nine physical therapy students, and a physician. They dispensed approximately 600 pills or treatments a day. Most medications and treatments were dispensed prior to meals in the infirmary or in the cabins at bedtime. However, medical care was available at all times in the infirmary.

Twenty-eight of 45 campers who were on maintenance treatment (62%) and six of those 13 campers on no maintenance (46%) visited the physician because their asthma worsened. Most received and responded to treatment with aerosolized beta agonists. However, half of the campers required major changes in their maintenance treatment to keep them active in camping activities. Seventeen of the campers (29%) were begun on oral steroids (four of these were on no medication when they came to camp).

Three campers (5%) were discharged because of illness. One had arrived at camp with a fever, sore throat and abdominal pains following an emergency room visit for asthma the previous night. She remained ill and was discharged on the third day of camp. Twenty-two campers (38%) subsequently visited the physician for sore throat. Fifteen did so within a 72 hour period beginning the ninth day of camp. This was thought secondary to a viral illness. Throat cultures showed no beta streptococcus. Many of the campers had abdominal and respiratory complaints at that time. There was a marked increase in visits to the physician for asthma at that time (Figure 1). One of these campers was refractory to SC epinephrine, IV aminophylline, IV steroids and was hospitalized in Peoria prior to transport to a hospital near his home. Another was too ill to participate in the final two days of camp activities and was sent home. Except for these three, the campers were able to participate in all the camp activities despite brief episodes of illness.

Because of this success, the second asthma camp had been scheduled at this writing for July 29th through August 5th, 1979. One hundred campers were anticipated. More information regarding the camp is available from the branch and affiliate office of the Illinois Lung Association.

January 14, 1981

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# Special Articles

## *A Mystery To Primary Care Physicians*

### Hearing Aids

By J. D. DONALDSON, M.D., FRCS (C) and J. L. OWENS, M.A., CCC/DECATUR

*The hearing handicapped, especially the elderly, receive scant interest from medical practitioners. We have forsaken this group of patients which ultimately constitute at least twenty percent of the population and allowed them to be serviced by businessmen rather than by professionals. This paper is prepared as an introduction to amplification and a guide to helping your patients receive more satisfactory fittings at less cost.*

Generally speaking, most middle-aged and elderly patients seek a physician's advice for hearing loss reluctantly. Many don't recognize or won't admit to hearing loss but come as a result of family pressure. As a group, they then tend to be susceptible to the door to door salesman who will "fix them up in the privacy of their homes." Also, wearing a hearing aid carries a greater stigma than wearing glasses. This maybe due in part to the poor service provided by an unsupervised industry in past years.

---

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**JERRY L. OWENS, M.A., CCC**, is an audiologist affiliated with Decatur Memorial Hospital, St. Mary's Hospital and Memorial Medical Center in Decatur. He is a member of both the Illinois Speech and Hearing Association and the American Speech-Language-Hearing Association.

A number of questions which might well be used by the family doctor to ascertain hearing acuity follows.

1. "Do you have to have the TV too loud for your family?" This is an obvious attempt to gauge hearing acuity against normal individuals.
2. "Do you have trouble understanding what is said in a noisy room?" Patients with sensorineural hearing loss often have no trouble in one to one conversation, but with any competing noise have poor discrimination accentuating their handicap.
3. "Do you have ringing in your ears?" Tinnitus may be generated from anywhere in the auditory system from external canal to temporal lobes. If continuously present, it should be a clue to investigate further.
4. "Do you work in a particularly loud environment?" Noise induced hearing loss is probably the most common industrial disease. An effort should be made to document this and to provide adequate sound protection.
5. "If you ask someone to repeat a statement, do they seem to shout at you?" Recruitment is almost pathomonic for cochlear sensorineural hearing loss.



**Table 1**  
**Glossary**

**Audiologist:** A professional paramedical person having at least a master's degree plus a year of directed supervision (like an internship), followed by written national examinations and received certification from the American Speech-Language-Hearing Association.

**Hearing Aid Dispenser (HAD):** A businessman who sells and services hearing aids on a prescription basis from an audiologist or a physician.

**Hearing Aid Dealer (Dealer):** A businessman who sells hearing aids and fits them. He sells directly to the public or from door to door. Dealers often called themselves certified hearing aid audiologists until federal legislation forbade this practice. Certification was by the industry, not any public body.

**Speech Reception Threshold (SRT):** That level in decibels at which the patient hears, understands and can repeat 50% of a list of two syllable words.

**Speech Discrimination (S.D.):** The percentage of mono-syllable words read from a phonetically balanced list which the patient repeats correctly when the volume is set at 30 dB above SRT level.

**Masking:** The use of noise in the non-test ear to insure the patient is not hearing sound transmitted from across the skull intended for the test ear.

6. "Do you have any episodes of dizziness when either you or the room seems to be moving?" Vertigo is often associated with sensorineural hearing loss.

### **Audiometry**

A basic audiometric workup must consist of the following: (1) Pure tone audiogram 250 Hz through 8000 Hz; (2) Bone conduction 250 Hz through 4000 Hz; (3) SRT and (4) S.D.

With adequate masking, these four tests will delineate most hearing losses completely and will provide an adequate basis for recommending evaluation for a hearing aid. Poor discrimination (less than 50%) or evidence of a conductive hearing loss should respectively suggest further investigation for a retrocochlear lesion or the possibility of surgical correction. Most audiologists charge thirty and forty dollars for these tests and will interpret them for the referring physician. Recommendations for ongoing care are usually provided.

### **Hearing Aid Evaluation**

If the patient's difficulty warrants placement of a hearing aid, the audiologist will usually recommend this. In the past, it was felt that sensorineural hearing loss contraindicated amplification. In fact, most aids are now fitted for this type of loss. The trick is to tailor the aid to amplify only those frequencies affected by the disease. If this is not properly performed, the aid will not be accepted by the patient.

The first step is to decide which ear to amplify. This decision is usually made on the basis of the audiogram and the S.D. scores. Often each ear will be tried. Account is taken of the patient's occupation. Whether the patient is left or right handed may have a bearing if they use the tele-

phone a lot. In children, binaural molds are essential if they are still getting middle ear effusions.

The second step is to manufacture ear molds. The authors feel that fitting an aid with stock office molds is improper, as the mold changes the frequency response of the aid. To fit an aid and then change the mold leads to patient dissatisfaction. Many types of molds are available. The choice of which type is used is made on the basis of which frequencies are to be amplified and how much amplification is required. This decision is usually made from the audiogram.

Once the patient has received his mold(s), he returns for the actual fitting. The audiologist selects two or three suitable aids from the many on the market. Each aid has a known frequency response curve. Generally, the aid is then fitted by increasing the volume to give a desired SRT and then repeating SD scores to give a maximum. Other tests include listening tasks in the presence of competing messages or sounds. The patient's aided ability to distinguish warbled pure tones or narrow bands of noise across specific frequencies is measured. Other adjustments are made within both the instrument and the mold to give high quality reproduction. The patient is asked to evaluate sound quality. One may sound "tinny" while another hasn't this problem. Finally the patient's subjective satisfaction is weighed with the various trial aids. The selected aid is then dispensed.

The patient is instructed in use and care of the instrument. In children, the maximum power output may be limited to prevent the child from turning it up too loud. He is asked to return in one month or if problems occur.

Finally, prior to the expiration of the trial period (45 days) the patient returns for a final evaluation. If he is satisfied and receiving definite bene-

fit he is advised to continue. If these cannot be demonstrated, he is advised to return the instrument.

### Types Of Hearing Aids

All hearing aids consist of the same essential components which may be arranged in varying fashion.

**Microphone**—This may be directional or non-directional. The microphone may be part of the aid or geographically isolated to prevent feedback or to pick up sounds from areas of silence to give the patient a sensation of direction.

**Amplifier**—After the microphone converts sound from physical to electrical energy, the amplifier magnifies the result. It may also alter the result using filters or devices to limit gain.

**Loudspeaker**—The electrical output from the amplifier is then reconverted to sound waves by the loudspeaker and delivered to the ear by tubing mold or a combination of both. The product is modified by the shape of the mold and by both the length and diameter of the tubing and vents.

Different configurations or styles are available.

**Ear level**—The aid is worn behind the ear and connected by tubing and mold. This is the most popular and most versatile.

**Body aid**—The microphone and amplifier are worn on the body connected to the loudspeaker at the ear by a wire. This type is now fitted in infants. It has low patient acceptance.

**Eyeglass**—The aid here is placed in the frame of the eyeglasses. The frame then delivers sound to the ears by tubing and molds. This is especially good for isolating the microphone from the loudspeaker as a wire can be run through the frame to the opposite side.

**All-in-the-Ear**—Essentially this is a vanity aid useful only for mild hearing losses. Most repairs require return to the factory.

### Recommending a Dealer or Dispenser

The authors prefer use of the audiologist and dispenser team, but some dealers do satisfactory work. The following points should be sought:

—The dealer or dispenser should work on a 'cost plus' fee basis which is disclosed to the patient. Most hearing aids cost between \$85 and \$170 from the factory. The patient should be aware of the cost of his aid and what the dispensing fee is and what the fee includes. With \$150 as a reasonable fee, most aids should be available for less than three hundred dollars.

—A trial period of at least 45 days is essential. If the patient is not happy with the result he should be able to return the aid at no cost other

than the cost of the molds. (Fifteen to twenty dollars each)

—The dispenser should provide aids from many companies. No one company makes aids to fit all losses.

—The dispenser should make essential repairs and provide loaner aids should the patient's aid have to be returned to the manufacturer.

—Full disclosure should be given the patient in the form of a contract. In this the dealer/dispenser will delineate the following: (a) factory cost; (b) dispensing fee; (c) services provided for that dispensing fee (repairs, cleaning, loaners, etc.); (d) trial period with guaranteed refund and (e) any warranty extension.

### Summary

Patients with hearing loss should be able to receive complete service (*i.e.*, medical examination, audiometry, hearing aid evaluation and fitting, the aid and servicing) for less than four hundred dollars. Hearing aids dispensed should be comfortably and beneficially used, not hidden in a drawer. By following the above guide, you can ensure that your patients receive adequate care of this forgotten special sense. ◀

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# Illinois Housestaff News

## *Holiday Thoughts*

This column has strived to bring resident physicians commentaries on issues of medical/social significance. In our zeal to inform residents of changes in graduate medical education, state and national legislation and local issues, we sometimes—unintentionally—overemphasize the day-to-day practicality of medical practice.

The holiday season brings an opportunity for reflection and reassessment. First-year house officers have completed one-half of their arduous schedule and are ready to decide if the physical and emotional demands of residency training are offset by the benefits which the practice of medicine brings. Senior residents are preparing to leave the protective environment of academic training and begin to cope with the realities of private practice. In 1892 William Osler, in remarks before the medical school at the University of Minnesota, proposed these guidelines as necessities for the student of medicine:

“In the first place acquire early the Art of Detachment, by which I mean the faculty of isolating yourself from the pursuits and pleasures incident to youth. By nature man is the incarnation of idleness, which quality alone, amid the ruined remnants of Edenic characters, remains in all its primitive intensity. Occasionally we do find an individual who takes to toil as others to pleasure, but the majority of us have to wrestle hard with the original ADAM, and find it no easy matter to scorn delights and live laborious days.

“Ask of any active businessman or a leader in a profession the secret which enables him to accomplish much work, and he will reply in one word ‘system’; or as I shall term it, the Virtues of Method, the harness without which only the horses of genius travel. There are two aspects of this subject: the first relates to the orderly arrangement of your work, which is to some extent enforced by the roster of demonstrations, and lectures, but this you would tell to supplement in private study by a schedule in which each hour finds its allotted duty. The other aspect of Method has a deeper significance. Hard for you to

reach, not consoling when attained, since it lays bare our weaknesses. The practice of medicine is an art, based on science. Working with science, in science, for science, it has not reached, perhaps never will, the dignity of a complete science, with exact laws, like astronomy or engineering.

“And thirdly, add to the Virtue of Method, the Quality of Thoroughness . . . in the present arrangement of the curriculum, few of you as students can hope to obtain more than a measure of it, but all can learn its value now, and ultimately with patience become living examples of its benefit. A knowledge of the fundamental sciences upon which our art is based—chemistry, anatomy, and physiology—not a smattering, but a full and deep acquaintance, not with all the facts, that is impossible, but with the great principles based upon them.

“The Art of Detachment, the Virtue of Method, and the Quality of Thoroughness may make you students in the true sense of the word, successful practitioners, or even great investigators; but your characters may still lack that which can alone give permanence to powers—the Grace of Humility. In these days of aggressive self assertion, when the stress of competition is so keen and the desire to make the most of ones self so universal, it may seem a little old fashioned to preach the necessity of this virtue, but I insist for its own sake, and for the sake of what it brings, that a due humility should take the place of honor on the list.”<sup>1</sup>

I would hope that we each have the time, during the holiday season to take a few moments and reflect upon the meaning of these timeless words—our own goals and aspirations within the framework of organized medicine today. ◀

LAWRENCE V. GRATKINS, M.D.  
CHAIRMAN, ISMS-RPS

### References

1. *Aequanimitas*, with other addresses by Osler. Published by Blakiston.

*\*This article represents the opinion of its author only, and does not reflect the opinions or policies of the Illinois State Medical Society or the ISMS Resident Physician Section.*

# Pulse of the ISMS Auxiliary

## *A Time For Giving*

BY MRS. HARLAN FAILOR, ISMSA PRESIDENT

Christmas may be the traditional time for giving, but the ISMS Auxiliary believes that when the cause is worthy, the giving should be year-round. The cause to which I refer is the ISMS Benevolence Fund.

Established by the Society's House of Delegates in 1940, the Benevolence Fund has for forty years demonstrated the willingness of the medical profession to take care of its own. Modest monthly allotments from the Fund allow needy physicians or their dependents to subsist without resorting to welfare.

Fund-raising for Benevolence has been a major activity of the Auxiliary since 1941. Mrs. August Martinucci, ISMSA Benevolence Chairman, reports that last year's Auxiliary contribution was \$10,458.90.

For some Auxilians, however, giving to Benevolence involves more than a monetary contribution. In July of 1976 the Medical Society proposed that two Auxiliary members sit with the ISMS Finance Committee when Benevolence matters were being considered. Then a few years later, when it was suggested that the Committee find some experienced social workers to help with Benevolence interviewing, the Auxiliary recognized another opportunity to assist the Society.

Mrs. Robert Reardon, District 5 Councilor and one of the Auxiliary's two representatives on the Benevolence Committee, sought out Auxilians with social service backgrounds. Six volunteers—all spouses of physicians and busy mothers—willingly accepted the responsibility of interviewing recipients and potential recipients for the Benevolence Committee:

Mrs. Richard Doud (Ruth Anne) is a graduate of Carleton College; she served four years as a caseworker for the Department of Public Aid in New York state.

Mrs. Don Hinderliter (Diane) is a graduate of Rockford Memorial School of Nursing and Northern Illinois University; she has been a psychiatric head nurse and a special project research nurse.

Mrs. Harold Keegan (Bonnie) is a registered nurse who received her degree from the Augustana Hospital School of Nursing in Chicago and completed undergraduate work for a degree in the Health Arts at the College of St. Francis. She has worked as a surgical supervisor and taught surgical nursing.



(Seated) Mrs. Robert Reardon; (Standing l. to r.) Mrs. Robert Kooiker, Mrs. Harold Keegan, Mrs. Don Hinderliter.

Mrs. Robert Kooiker (Meinard) received child welfare training at the University of Chicago and graduated from the University of Iowa with degrees in sociology and special education; she was a social worker and special services teacher in Minnesota for eight years.

Mrs. Louis Tarsinos (Electra) is a graduate of Roosevelt University and the University of Chicago School of Social Service Administration; she has been a caseworker with the Cook County Department of Public Aid and a school social worker in Illinois and Wisconsin.

Mrs. Karl Sohlberg (Nancy) received her nursing degree from the Russell Sage College in Troy, New York. Her experience includes work as a school nurse, teaching and activities in the mental health field; she is presently a member of the Region 1B Human Rights Authority, Illinois Guardianship and Advocacy Commission.

It has been said that the greatest gift one can give is the gift of time, because it is the giving of one's life.

Searching for that special present?

Pondering the perfect offering?

At this *time of giving*, we might all consider the *giving of time*. ◀



# Summary of Actions

## 1980 Interim Session

### House of Delegates

*The ISMS House of Delegates met in Peoria October 25-26, 1980, and acted on the following resolutions and reports. Due to the complexity of amendments to policy manual statements, only the approved, revised policy statements are reflected in this text. Persons wishing to study the nature of approved changes may refer to the October 1980, Reference Issue of the IMJ, where the former policy statements were published.*

#### OLD BUSINESS

1. Defeated a resolution calling upon ISMS to dissolve the Illinois Council on Continuing Medical Education and assign ICCME duties to appropriate ISMS Councils and Committees. (79N-13)
2. Amended the ISMS Policy Manual statement entitled "Autonomy of County Medical Societies" to read:

##### **AUTONOMY OF COUNTY MEDICAL SOCIETIES**

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society. (80A-19).

3. Deleted the ISMS Policy Manual appendix on Multiphasic Health Testing and amended the Policy Manual statement entitled "Multiphasic Screening" to read:

##### **MULTIPHASIC SCREENING**

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the state of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities. (80A-35).

4. Defeated a resolution calling upon ISMS to endorse proposed modifications in Illinois Department of Public Health Rules on PKU

and T-4 testing, because recent legislation has rendered the question moot. (80A-18)

5. Defeated a resolution calling upon ISMS to "strongly disapprove of the current (Illinois Health Facilities Planning Board) policy of planning for the past" and "offer its expertise in developing methodology for utilization of past experience to develop future need projections in health planning." The House was satisfied that the resolution's intent is addressed in the existing IHFPB review criteria. (80A-5)

#### REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

1. Referred to the Board of Trustees a proposed Bylaws amendment which would bring Ch. X, Section 11 into conformity with Sub. 80A-19 as amended. The proposed amendment would delete required component society adherence to the AMA Constitution and Bylaws and Principles of Medical Ethics. (Report D of the Board of Trustees—80A-19)
2. Amended the Bylaws to provide that resolutions presented by the Resident Physician Section and Student Business Section be approved or rejected for consideration by the House on the same basis used for resolutions presented by any other delegate. (80A-18)
3. Amended Bylaws Ch. IX to provide for task forces in the organization structure of the Society. Task Forces will be defined in Chapter IX of the Bylaws as follows:

"Section 4. Task Forces. A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the Presi-

dent upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.”

The House also amended the Bylaws to include appointment of task forces among duties of the president and ex-officio task force membership among rights of the president, speaker of the House and chairman of the Board. (80A-40)

4. Filed for information Supplemental Report #1 of the Illinois Delegation to the American Medical Association.

## REFERENCE COMMITTEE A

1. Amended the Policy Manual statement entitled “Audits and Surveys” to read:

### AUDITS AND SURVEYS

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additionally, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned. (80A-39)

2. Deleted the Policy Manual statement entitled, “Membership of Osteopathic Physicians in ISMS.” The House was satisfied that special provision for osteopathic membership was no longer necessary. (80I-4)
3. Replaced the Policy Manual statement entitled “AMA-ERF” with the following:

### AMA-ERF

The AMA-ERF contribution for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by

advising ISMS in writing.

This statement will be included on ISMS dues bills. (80I-12)

4. Defeated a resolution which would have mandated the ISMS Board of Trustees to: (A) Investigate why the Illinois State Medical Inter-Insurance Exchange raised its rates for Categories I and II; (B) Seek recission of these increases; and (C) Prevent recurrence of same. (80I-26)
5. Defeated a resolution which would have: (A) Divided ISMS into two autonomous departments with separate membership for those advocating preservation and expansion of the private practice of medicine without third party intervention and those choosing to practice in cooperation with third party plans; and (B) Directed the Illinois Delegation to seek adoption of a similar resolution by the AMA House of Delegates. (80I-33)
6. Defeated a resolution calling for establishment of: (A) A “New Doctor-Patient Coalition” to challenge expanding government power, especially in the area of national health insurance plans; and (B) A private sector alternative to current established “public policies” in medical and hospital care services to provide free choice to the consumer and provider of such services. (80I-38)
7. Instructed the Illinois Delegation to introduce a resolution at the 1980 AMA Interim Meeting to amend the AMA Bylaws to read: *“Under no circumstances may a physician be considered eligible for Direct Membership whose application for membership has been considered and rejected by a local county medical society or state medical association or whose membership has been terminated by a local county medical society or state medical association for reasons other than non-payment of dues.”* (80I-42)
8. Filed for information Report A of the Board of Trustees, detailing implementation of all resolutions adopted by the House at its 1980 Annual Meeting.

## REFERENCE COMMITTEE B

1. Supported two concepts regarding payment to physicians who accept Medicare assignment: (A) Such payments should be made directly to the physician; and (B) When a payment is incorrectly forwarded to the patient, Medicare should make full payment to the physician upon verification of that error. (80I-10)



2. Defeated a resolution calling upon ISMS to: (A) Condemn the Illinois Medicaid program as "an inferior health care delivery system;" (B) Organize a consortium of affected consumer groups to develop plans for "a level of care approaching that of Medicare;" and (C) Present such plan to the Governor for implementation through IDPA. (80I-34)
3. Defeated a resolution calling upon ISMS to: (A) Demand that IDPA discontinue office audits of physician records until a "workable" audit procedure can be developed; (B) Establish a "committee of peers" to develop "acceptable" criteria for the office visit codes; (C) Institute legal action against IDPA should the Department refuse to accept such new criteria; (D) Allocate funds up to \$50,000 for this purpose; and (E) Appoint an ad hoc committee to develop plans of action. The House believed the intent of this resolution has been or is being met through existing ISMS channels for negotiation. (80I-35)

## REFERENCE COMMITTEE C

1. Amended Policy Manual Statements entitled "Occupational Health," "Athletic Programs," "Blood Procurement," and "Laboratories," to read as follows:

### OCCUPATIONAL HEALTH

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged. (80I-1)

### ATHLETIC PROGRAMS

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment. (80I-7)

### BLOOD SERVICES

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county. (80I-14)

### LABORATORIES

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches. (80I-15)

2. Referred to the Board of Trustees for study a proposed statement supporting: (A) The

principle that "existing recognized guidelines be followed by all medical researchers"; and (B) Penalties for violations of patients' rights as enumerated "in existing recognized guidelines pertaining to human experimentation." (80I-13)

3. Defeated a resolution which called upon ISMS to support "a physician's right to accept or reject a self-referred patient." The House determined that the particular instance described in this proposal is a private matter between physician, medical staff and hospital. (80I-25)
4. Referred to the Board of Trustees for study proposals to: (A) Form a task force to investigate new means to improve the retention and distribution of physicians in medically underserved areas of Illinois; (B) Investigate ways to improve residency programs in order to attract and retain medical graduates in Illinois; (C) Oppose any type of mandatory learning contracts for Illinois medical students; and (D) Oppose any tuition increase in statewide schools when such an increase is designed to induce students to sign learning contracts. (80I-29)
5. Defeated a resolution which called upon ISMS to "reassess its position of passive acceptance of any special discrimination against its members or potential members." (80I-32)
6. Supported the concept that "Illinois medical students, whose medical education is supported by Illinois tax money, be encouraged to remain in Illinois to practice." (80A-1)

## REFERENCE COMMITTEE D

1. Amended Policy Manual statements entitled "Press," and "Reference Service," to read as follows:

### PRESS

In order to provide the public with prompt and accurate information on all health related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The State Society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications. (80I-2)

## REFERENCE SERVICE

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved. (80I-8)

2. Re-titled and amended the Policy Manual statement entitled "Membership in Paramedical and Service Organizations" to read:

## PARTICIPATION IN SERVICE ORGANIZATIONS

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois. (80I-3)

3. Deleted from the Policy Manual those statements entitled, "Public Safety," "Surveys," and "Osteopaths, Association with." (80I-5, 80I-6, 80I-17)
4. Referred to the Board of Trustees proposed amendments to the Policy Manual Statement entitled "Hospital Records and Their Availability." (80I-16)
5. Mandated ISMS to immediately communicate to the appropriate county society any final disciplinary action taken by the Illinois Department of Registration and Education Medical Disciplinary Board affecting a physician's license to practice. (80I-9)
6. Defeated a resolution which called upon ISMS to develop "a precise, specific definition of medical malpractice" for recommendation to the Illinois State Legislature. (80I-19)
7. Commended founding members of the Medical Council on Handgun Violence for their concern over the problem of handgun abuse, and encouraged them in their involvement. (80I-20)
8. Instructed the Board of Trustees to develop specific legislation to eliminate mandated benefits in health insurance policies for consideration by the House of Delegates at its 1981 Annual Meeting. (80I-21)
9. Referred to the Board of Trustees for study proposed action to prevent the Health Care

Financing Administration from authorizing payment denial by intermediaries when a physician is under investigation for questionable practice patterns under PSRO review. The proposal also recommends the AMA House of Delegates be urged to take similar action. (80I-22)

10. Mandated the Board of Trustees to seek introduction of legislation in the 1981 General Assembly to "sunset" the existing cervical pap smear law by automatic repeal effective January 1, 1986. The current statute requires that female patients in hospitals be offered a cytological study of the cervix if one had not been performed in the preceding 12 months. (80I-23 and 80I-31)
11. Directed ISMS to "actively oppose" efforts of the Department of Health and Human Services to regulate manufacture and sale of AFP (Alpha-fetoprotein) diagnostic kits, and instructed the Illinois Delegation to seek support of the AMA House of Delegates. (80I-24)
12. Referred to the Board of Trustees for study a resolution calling upon ISMS to support the enactment of legislation requiring use of a full-face helmet when riding or driving a motorcycle. Testimony had determined that the original motorcycle helmet law had been found unconstitutional, and further study of the proposal was needed. (80I-27)
13. Directed the Society to urge the Chicago Tribune and Chicago Sun Times newspapers to refuse to accept cigarette advertisements. (80I-28)
14. Defeated a resolution calling upon ISMS to: (A) Endorse the Equal Rights Amendment; and (B) Introduce a resolution calling for AMA to endorse the Amendment. (80I-30)
15. Defeated a resolution which would have resulted in ISMS introduction of an amicus curiae brief on behalf of a suit entered by Robert H. Libman, M.D. (80I-43)

## SPECIAL ACTION

1. Expressed condolences to the families of deceased ISMS past presidents E. P. Coleman, M.D., Willis I. Lewis, M.D. and Edward A. Piszczek, M.D. Cited each for service with distinction, honor and devotion to the welfare of patients, the public and their profession. ◀



# Actions On Resolutions

## 1980 Interim Meeting

### House of Delegates

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
<b>OLD BUSINESS</b>			
79N-13 (BoT Report B)	William H. Isham, M.D.	Accomplishment of Goal by ICCME	Not adopted
80A-1 (BoT Report C)	Charles J. Jannings, M.D.	Tuition Reimbursement	Referred to Refer- ence Committee "C"
80A-19 (BoT Report D)	Morris T. Friedell, M.D.	Deletion of Policy Manual Statement on "Autonomy of County Medical Socie- ties"	Substitute Adopted as Amended & Re- ferred with BoT Re- port D to Reference Committee on Const. & ByLaws for Consideration in Developing Amendments to By- Laws, Chapter X, Sec. 11, to bring it into Conformity with this new Policy Statement
80A-35 (BoT Report E)	Morris T. Friedell, M.D.	Amendment of Policy Manual Statement on "Multiphasic Screening"	Adopted as Amend- ed
80A-18 (BoT Report F)	J. Robert Thomspson, M.D.	PKU and T-4 Testing; IDPH Rules	Not Adopted
80A-5 (BoT Report G)	Walt Stevenson, III, M.D.	Use of Projected Utiliza- tion Rates by the Illinois Health Planning Board	Not Adopted

### REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

Sub 80A-19 as Amended & BoT Report D	Morris T. Friedell, M.D.	Autonomy of County Med- ical Societies	Proposed Amend- ment to ByLaws, Ch.X., Sec. 11 to bring it into Con- formity with Sub. 80A-19 as Amended was Referred to BoT
80I-18	Lawrence L. Hirsch, M.D.	Amendment to ByLaws Regarding Introduction of Resolutions by RPS and SBS	Adopted

<i><b>NUMBER</b></i>	<i><b>INTRODUCED BY</b></i>	<i><b>SUBJECT</b></i>	<i><b>ACTION</b></i>
80I-40	Lawrence L. Hirsch, M.D.	Revision of Chapters VI and IX of the ByLaws	Adopted as Amended

### **REFERENCE COMMITTEE "A"**

80A-39	Morris T. Friedell, M.D.	Amendments to the ISMS Policy Manual Statement on "Audits & Surveys"	Adopted
80I-4	Alfred J. Kiessel, M.D.	Deletion of Policy Manual Statement on "Membership of Osteopathic Physicians in ISMS"	Adopted
80I-12	Jere Freidheim, M.D.	Substitution of Policy Statement on "AMA-ERF"	Adopted
80I-26	Samuel J. Schimel, M.D.	Professional Liability Insurance Rates	Not Adopted
80I-33	Michael R. Saxon, M.D.	Division of ISMS into Self-Governing Public and Private Medical Care Departments	Not Adopted
80I-38 (Revised)	Michael R. Saxon, M.D.	Doctor-Patient Coalition... A Constructive Alternative to NHI	Not Adopted
80I-42	Morris T. Friedell, M.D.	Direct Membership in AMA	Adopted

### **REFERENCE COMMITTEE "B"**

80I-10	Cyril C. Wiggishoff, M.D.	Medicare Assignments	Adopted as Editorially Changed
80I-34	George Lagorio, M.D.	Second Class Medical Care (The Poor Become Poorer)	Not Adopted
80I-35	George Lagorio, M.D.	Illinois Department of Public Aid Excess Requirements Resolution	Not Adopted

### **REFERENCE COMMITTEE "C"**

80A-1 (BoT Report C)	Charles J. Jannings, M.D.	Tuition Reimbursement	Substitute Adopted
80I-1	Alfred J. Kiessel, M.D.	Deletion of Policy Manual Statement on "Occupational Health"	Substitute Adopted as Amended



<i><b>NUMBER</b></i>	<i><b>INTRODUCED BY</b></i>	<i><b>SUBJECT</b></i>	<i><b>ACTION</b></i>
80I-7	Alfred J. Kiessel, M.D.	Replacement of the ISMS Policy Statement on "Athletic Programs"	Adopted
80I-13	Gilbert Bogan, M.D.	Medical Research Involving Human Experimentation	Referred to BoT
80I-14	Fred Z. White, M.D.	Revision in Policy Manual Statement on "Blood Procurement"	Substitute Adopted
80I-15	Fred Z. White, M.D.	Revision in Policy Manual Statement on "Laboratories"	Adopted
80I-25	James P. Campbell, M.D.	Freedom of Choice	Not Adopted
80I-29	Ronald Davis, SBS	Mandatory Learning Contracts	Amended Substitute Referred to BoT
80I-32	Wayne K. Leimbach, M.D.	Tuition Reimbursement as Previously Introduced in Resolution 80A-1	Not Adopted

#### **REFERENCE COMMITTEE "D"**

80I-2	Alfred J. Kiessel, M.D.	Amendment of Policy Manual Statement on "Press"	Adopted as Editorially Changed
80I-3	Alfred J. Kiessel, M.D.	Deletion of Policy Manual Statement on "Membership in Paramedical and Service Organizations"	Substitute Adopted
80I-5	Alfred J. Kiessel, M.D.	Deletion of Policy Manual Statement on "Public Safety"	Adopted
80I-6	Alfred J. Kiessel, M.D.	Deletion of Policy Manual Statement on "Surveys"	Adopted
80I-8	Alfred J. Kiessel, M.D.	Replacement of ISMS Policy Statement on "Reference Service"	Substitute Adopted
80I-9	Arthur Traugott, M.D.	Final Disciplinary Action & Reporting by the Illinois Dept. of R & E	Substitute Adopted as Editorially Changed
80I-16	Fred Z. White, M.D.	Revision of Policy Manual Statement on "Hospital Records & Their Availability"	Referred to BoT

<i>NUMBER</i>	<i>INTRODUCED BY</i>	<i>SUBJECT</i>	<i>ACTION</i>
80I-17	Alfred J. Kiessel, M.D.	Deletion of Policy Manual Statement on "Osteopaths, Association with"	Adopted
80I-19	Robert F. Hamilton, M.D.	Legal Definition of Medical Malpractice	Not Adopted
80I-20	Ronald Davis, SBS	Illinois Medical Council for Handgun Control	Adopted as Amended
80I-21	Robert R. Hartman, M.D.	Legislation Giving Ins. Policy Holders the Right to Freely Choose All of the Provisions Relating to Services Covered by Health Professionals Providing Those Services in Health Ins. Policies	Substitute Adopted as Editorially Changed
80I-22	Joseph R. O'Donnell, M.D.	Presumption of Liability of a Provider under PSRO Review	Referred to BoT
80I-23	Wayne N. Leimbach, M.D.	Cervical Pap Smears as Mandated by Illinois Law	Substitute 80I-23 Adopted as Amended in Lieu of 80I-23 & 80I-31
80I-24	Joseph R. O'Donnell, M.D.	Regulations on the Sale and Use of AFP Diagnostic Kits	Adopted
80I-27	Ronald M. Davis, SBS	State Motorcycle Helmet Law	Referred to BoT
80I-28	Ronald M. Davis, SBS	Cigarette Advertisements	Adopted
80I-30	Ronald M. Davis, SBS	Equal Rights Amendment	Not adopted
80I-31	Raymond Hoffman, M.D.	Frequency of Pap Smear Testing	Substitute 80I-23 Adopted as Amended in Lieu of 80I-23 & 80I-31
80I-43	Morris T. Friedell, M.D.	Filing of an Amicus Brief on Behalf of Dr. Libman	Not Adopted

## **SPECIAL ACTION**

**The Following Resolution Was Considered by the House of Delegates Without Referral to a Reference Committee**

Memorial Resolution	Herschel Browns, M.D.	Memorial to Three Illinois State Medical Society Past Presidents Who Died During the Summer of 1980 E.P. Coleman, M.D. Willis I. Lewis, M.D. Edward A. Piszczek, M.D.	Adopted
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# Student Business Section in Action

## Promoting Death and Disease

*This is the first of a five-part series on cigarette advertising.*

As much as half of the U.S. mortality is due to unhealthy behavior or lifestyle. That is the conclusion of the Surgeon General, in his first Report on Health Promotion and Disease Prevention (*Healthy People*) released in 1979. It should be repeated over and over again in the halls of medicine until we all give it the attention it deserves. No other single statistic so strikingly points out the need to restructure our health care system toward the prevention of disease.

As we shift our emphasis from cure to prevention, it seems natural to begin by concentrating on the most deadly of our unhealthy habits. It turns out that *cigarette smoking is the single most preventable cause of death in the United States*. It is estimated to account for 346,000 premature deaths each year: 80,000 from lung cancer; 22,000 from other cancers; 225,000 from cardiovascular disease; and 19,000 from chronic obstructive pulmonary disease. That is more than the number of annual deaths related to alcohol (200,000), and almost seven times the number of fatalities due to motor-vehicle accidents (50,000). Cigarette smoking claims more American deaths each year than did all of World War II—*year after year*. Seven times as many Americans die from smoking each year than died in Viet Nam—*year after year*. And this is to say nothing of the 10 million Americans who currently suffer from debilitating chronic diseases caused by smoking, or the health care costs to treat them (\$8 billion), or the corresponding economic cost to society in terms of lost earnings and fires (\$19 billion).

By now it should be clear that cigarette smoking is Public Health Enemy #1. Again, it seems only natural to examine what is possibly the most

important aspect of this enormous problem; namely, cigarette advertising.

The tobacco industry promotes death and disease by spending \$800 million per year on cigarette advertising. That is \$2.2 million per day, or \$91,000 per hour, or \$1500 per minute, spent trying to entice as many men, women, and yes, children to commit "slow-motion suicide." Put another way, the industry spends \$2312 on advertising for every premature death that its product causes. The government, by contrast, spends less than \$1 million on its anti-smoking educational campaign. Thus the industry's message to the public is practically unopposed in depicting smoking as sexy, sophisticated, socially acceptable, and above all, safe. So it should not be terribly surprising why smokers, only 25% of whom say their physicians have told them to quit, have a hard time doing so. Or why teenagers are so inclined to take up the habit. They are simply bombarded by billboards, posters, transit ads, and almost every newspaper and magazine in the country telling them that smoking is as good as Mom and apple pie.

Over the next four months, this column will discuss a few of the most important aspects of this issue. Part 2 will review the political history of attempts to regulate cigarette advertising, explaining why it is essentially unregulated today. Part 3 will cover the advertising themes that cigarette companies employ to promote their product. Part 4 will concern itself with how the tobacco industry's huge advertising purchases allow it to manipulate the media into a virtual silence on the smoking issue. And finally, Part 5 will offer one way in which the medical profession can begin to fight back—with more than just words. ◀

Ronald M. Davis  
Delegate, ISMS-SBS

*This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Student Business Section.*

# Abstracts of Board Actions

(Continued from page 378)

## PROFESSIONAL LIABILITY LEGISLATION

ISMS will seek legislation in the upcoming General Assembly session that would modify "special damage" requirements and allow a wrongfully-sued individual to more easily bring legal action against the party who initiated an unwarranted suit.

## MEDICARE FEES

The Society will urge the Illinois Congressional delegation to oppose that portion of S 2885—a spending limits bill—that would establish a state maximum on Medicare payments for specific procedures.

## MEMBERSHIP RECRUITMENT

As part of membership recruitment/retention efforts, ISMS will prepare a report outlining major ISMS activities and accomplishments during 1981 that will be: (1) Published in a year-end edition of *Action Report* sent to all members; and (2) Included with the second of two recruitment letters scheduled for mailing to the 7,000 non-member physicians in Illinois.

## SPECIAL PROGRAMS

Acting on requests concerning special programs, the Board voted to:

- Co-sponsor—with the Chicago Medical School's Dept. of Rehabilitation Medicine—a program on "Challenge of the Low Back Patient in Compensation Injuries," April 29, 1981, at the Ambassador West Hotel, Chicago. The program will offer Category 1 CME credit.
- Authorize the Public Affairs Committee to develop a special program designed to involve Auxiliary members in ISMS legislative activities. The program will include local sessions that allow Auxiliary members to meet newly-elected legislators, and various approaches to encourage Auxiliary members to monitor local developments regarding HMOs, IPAs and HSAs.
- Affirm its support of the ISMS-administered Illinois Jail Health Program—designed to improve health services provided to inmates—and seek additional program funding from appropriate private foundations and government agencies.
- Establish with the Chicago Bar Assn. a mediation service designed to resolve—prior to trial—disputes between attorneys and physicians over fees that would be paid to a treating physician/expert witness.
- Cosponsor an AMA-produced negotiations training program in conjunction with the 1981 Interim Session of the House of Delegates.

## PATIENT EDUCATION

In 1981, the Society will begin limited publication of a patient education newspaper for distribution in physicians' offices. The "newspaper" will combine health education with general information—and the Society's views—on socioeconomic issues, including health costs, NHI etc. Another aspect of patient education will be the distribution to all Illinois TV stations of filmed public service announcements on the patient's role in controlling health costs and the importance of immunization.



## CATEGORIZATION OF HOSPITALS

The Board adopted the following position regarding categorization of hospitals:

Categorization is the application of medical criteria approved by medical societies, with broad input, designed to assist physicians in the provision of appropriate care.

Regarding criteria development and categorization enforcement, ISMS recommends adherence to the following guidelines:

- I. Criteria for categorization of each area of care should be developed by appropriate medical specialists, including those in primary care. Criteria should be general enough to be acceptable to the majority of members of the medical profession providing this care.
- II. Categorization criteria should take into account: A) The demographics of the community to be served; B) The quality of care to be provided; and C) The cost incurred in meeting the criteria.
- III. No criteria for categorization should be implemented or enforced by any organization or body prior to their review and acceptance or modification by an appropriate combination of local, state and national medical societies.
- IV. Horizontal categorization, indicating the overall ability of a facility to provide care, should be used to inform the public regarding care available in that institution.
- V. Vertical categorization, which classifies specific care areas of a facility, should be performed internally, according to previously approved criteria, and used by that medical staff to assess its own capabilities in specific disease treatment areas.
- VI. Categorization of a hospital at a certain level for one type of care should not be used as a standard for judging the quality of the entire hospital or any of its other services, nor should such categorization require the facility to provide identical levels of care in all clinical areas.
- VII. The compliance with the vertical and horizontal criteria should be assessed by an independent evaluating group. Such groups must insure physician participation in the evaluation process.
- VIII. Categorization should primarily serve as a mechanism to educate physicians and other health care providers, so that the level of initial resuscitative care and referral patterns could be improved to provide appropriate care for certain conditions.
- IX. Categorization plans should also take into account that specialty center institutions need not assume the responsibility for the care of the patient until recovery, but should allow for cooperating institutions to participate in the full recovery of the patient, when appropriate.
- X. Hospitals not meeting accepted criteria for a particular type and level of care should not advertise provision of such care.

## IDPA DRUG MANUAL

The following drugs were approved for inclusion in the IDPA Drug Manual: *Midrin*, *Minizide*, *Yutopar* and *Micrainin*. ISMS will recommend that IDPA remove from the Drug Manual any preparations containing *Phenacetin* because of demonstrated renal toxicity.

## ICCME BOARD OF DIRECTORS

The Board recommended that the ISMS Executive Committee—when it meets as ICCME corporate members—elect the following physicians as ISMS representatives to the ICCME Board of Directors: Drs. *E. Chester Bone*, Jacksonville; *Dean Bordeaux*, Peoria; *Alfred Clementi*, Arlington Heights; *Kenneth Hurst*, Naperville; *William Lees*, Lincolnwood; *Robert Prentice*, Springfield; *Donald Pochyly*, River Forest; *Fred White*, Chillicothe; and *Roger Wujezk*, Litchfield.

Beginning next year, the ISMS Committee on Accreditation will: (1) Serve as a selection committee for the ICCME Board of Directors with nominations subject to the approval of the ISMS Executive Committee; and (2) Recommend to the ISMS Executive Committee proposed rules to govern how ICCME Board members and officers are chosen and their suggested tenure.

## APPOINTMENTS/NOMINATIONS

The Board approved the following appointments to ISMS committees:

- *Dr. Clinton Compere*, Chicago—Ad Hoc Committee on Loss Prevention Education.
- *Dr. John Lumpkin*, Chicago—Government Affairs Council.
- *Dr. Michael Victor*, Buffalo Grove—Medical-Legal Council.

Nominated for appointment to State bodies were:

- *Dr. Robert Swartz*, Arlington Heights—IDPH Ambulatory Surgical Treatment Licensing Board.
- *Dr. Alfred Kiessel*, Decatur—re-appointment to Clinical Laboratory & Blood Bank Advisory Board.
- *Dr. Fred White*, Chillicothe—IDPA Medical Care Advisory Committee, which will advise the Department on major issues affecting Medicaid, such as proposed policy changes.
- *Dr. Joseph Winterhalter*, Jacksonville—IDPH task force established to develop a plan for a coordinated emergency medical services system which will include hospital categorization.

ISMS will nominate *Dr. Vincent Costanzo*, Chicago, for appointment to the IDPH Advisory Committee for Family Practice Residency, and recommend reappointment of *Dr. Fred White*, Chillicothe, *Dr. Richard Moy*, Springfield, and *Mrs. Helen Terr*, E. St. Louis. *Sister Stella Louise*, president of St. Mary of Nazareth Hospital, Chicago, also will be nominated for appointment to the Committee.

Nominated to fill vacancies on AMA councils were: *Dr. Lawrence Hirsch*, Chicago,—Council on Long Range Planning & Development; and Drs. *Morris Friedell*, Chicago, and *P. John Seward*, Rockford—Council on Legislation.

*Dr. Peter Friedell*, Chicago, was named the ISMS representative to the Illinois Cancer Council. ◀

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# "I Quit" Clinics

# EKG

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

Bi-Monthly	Skokie Valley Hospital	Skokie
January 5	Condell Memorial Hospital & A.C.S.	Libertyville
January 5	Highland Park Hospital & A.C.S.	Highland Park
January 6	South Suburban Hospital & A.C.S.	Hazel Crest
January 12	Geneva Community Hospital & A.C.S.	Geneva
January 12	Resurrection Hospital A.C.S.	Chicago
January 20	Lutheran General Hospital & A.C.S.	Park Ridge
January 26	Christ Hospital & A.C.S.	Oak Lawn
January 26	Ingalls Memorial Hospital & A.C.S.	Harvey
February 2	Quincy College & 7th Day & A.C.S.	Oak Lawn
February 9	St. Therese Area Trauma Satellite & A.C.S.	Lake Villa
March 9	Lake Forest Hospital & A.C.S.	Lake Forest
March 23	Christ Hospital & A.C.S.	Oak Lawn
April 14	Lutheran General Hospital & A.C.S.	Park Ridge

(Continued from page 379)

Answers: 1. E 2. A, B, C

The lead II ECG rhythm strip shows a paroxysmal supra-ventricular tachycardia. The QRS of the tachycardia is normal in duration and resembles the contour of the QRS of the sinus beats. P waves are not clearly seen during the tachycardia. Some textbooks call this a reciprocating or reentry or AV junctional tachycardia. The tachycardia is thought to be due to a reentry mechanism. For reentry to occur, two separate pathways are required. These two pathways can be anatomically or functionally separate and have different refractory periods. In addition, unidirectional block of an impulse occurs in the other pathway. When this happens, the stage is set for reentry or circus motion of an impulse. In our patient the premature ventricular beat (fourth beat second panel) must have delivered a retrograde impulse into the AV junction. It could have blocked in one pathway and conducted slowly in the second pathway. This would allow a reentry or circus movement to begin. The R-R cycle following the premature ventricular beat is longer than the R-R cycle of the tachycardia while the next R-R cycle of the tachycardia is shorter. Carotid sinus massage (CSM) increases the refractoriness of the AV junction and the last R-R cycle of the tachycardia lengthens slightly before sinus rhythm resumes. The PR interval of the sinus beats is prolonged to 0.24 seconds for a first degree AV block. The P wave duration is greater than 0.12 seconds in lead II for left atrial enlargement. Digitalis is the treatment of choice, but Propanolol is also very effective. Digitalis, Propanolol, and carotid sinus massage all increase the AV junctional refractoriness. This will make the development of a circus movement there more difficult. Raising the blood pressure with Phenylephrine or Methoxamine is done to induce an increase in vagal tone by a carotid sinus mechanism. It probably should not be done in patients with heart disease since it increases the work of the heart. This increase in work and in myocardial oxygen demand would be in addition to the workload of the tachycardia. Our patient responded to an increase in his digitalis dosage. He has had no further tachycardias and his PR interval has remained stable. ◀

# VIEWBOX

(Continued from page 381)

## DIAGNOSIS: Idiopathic Retroperitoneal Fibrosis—Computed Tomography.

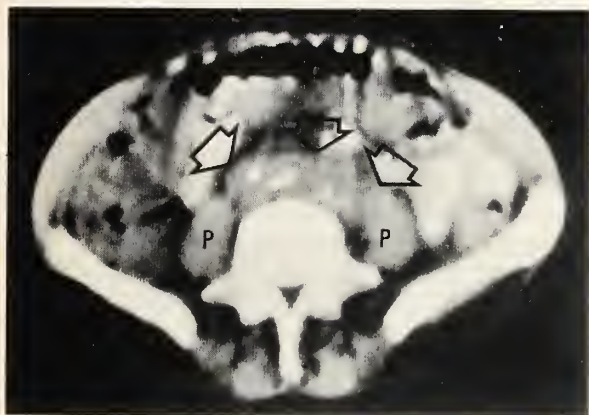


Figure 3

C.T. of patient with retroperitoneal fibrosis. A smooth symmetric mantle of tissue (arrows) extends across L5 enveloping the calcified iliac arteries, veins and ureters. Fibrosis extended to L3. (p = psoas muscle)

Lymph node metastasis or lymphomatous nodes large enough to cause bilateral hydronephrosis would displace the ureters. Periaortic nodes displace the ureters laterally while iliac nodes displace the ureters medially. A pelvic mass could obstruct both ureters but there is no mass density in the pelvis and the bladder is not displaced or deformed. Bladder outlet obstruction is not causing the hydronephrosis since the distal ureters and bladder are not dilated and the bladder dome is smooth. In this patient there is bilateral symmetric caliectasis, pyelectasis and ureterectasis. The proximal ureters are dilated while the distal ureters are normal in caliber. These findings are very suggestive of retroperitoneal fibrosis in a middle aged man with insidious back pain and an elevated sedimentation rate.<sup>1,2</sup>

Lymphography has shown collateral vessels and obstruction of vessels in patients with retroperitoneal fibrosis. These findings are not specific. Lymph node defects have also been reported

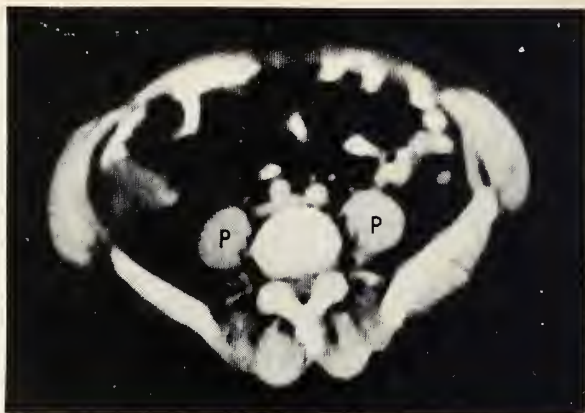


Figure 4

Normal patient. C.T. at L5. Iliac arteries and veins just anterior to L5 are clearly outlined. (p = psoas muscle)



Figure 5

Patient with lymphoma. C.T. at L5. The iliac vessels are obliterated by an asymmetric soft tissue mass (arrows) with an irregular margin. (p = psoas muscle)

and these are not specific since they resemble defects found in metastatic disease. Some patients with advanced urographic changes have had normal lymphograms.

Venography and arteriography demonstrate narrowed and obstructed vessels in some patients with retroperitoneal fibrosis but would only be indicated if a patient had signs or symptoms such as leg edema, claudication, or portal hypertension suggesting vascular compromise.

Ultrasonography has demonstrated the fibrotic plaque of retroperitoneal fibrosis and in addition is an excellent means of identifying an abdominal aneurysm, which is one cause of retroperitoneal



fibrosis.

Computed tomography is the preferred means of making the diagnosis of retroperitoneal fibrosis.<sup>3,4</sup> The retroperitoneum is exquisitely depicted and in addition, following injection of intravenous contrast media, the opacified ureters can be easily identified even if they are not dilated.

The idiopathic type of retroperitoneal fibrosis accounts for about 75% of all cases. This non-suppurative inflammatory fibrosis of the retroperitoneum is related to the fibrosis occurring in orbital pseudotumor, Reidel's struma, sclerosing cholangitis, retractile mesenteritis, and sclerosing mediastinitis. The fibrosis grossly resembles malignancy. A hard grayish plaque often envelopes the aorta, inferior vena cava and ureters. Involvement usually extends from the renal pedicle to the sacral promontory but can range from the diaphragm to the bladder. The fibrotic plaque can extend along the major aortic branches and almost all abdominal and retroperitoneal structures have been affected either directly or more often because of compromise of arteries, veins, and nerves.

The primary histologic finding in retroperitoneal fibrosis is collagenous connective tissue. There are varying degrees of cellular infiltrate indicating non-suppurative inflammation. Vasculitis and perivascularitis have been described. Patients with retroperitoneal fibrosis provoked by metastatic neoplasm or lymphoma have few malignant cells in a large amount of desmoplastic tissue. The sparse neoplastic cells are easily missed if generous biopsies are not obtained.<sup>1</sup>

Fibrosis due to specific causes is histologically similar to the idiopathic type. The most common specific causes of retroperitoneal fibrosis are methysergide and malignancy. Bilateral ureteral obstruction associated with abdominal aortic aneurysm and perianeurysmal fibrosis has been reported in 16 patients with and without leakage of blood.<sup>3</sup> Ureteral obstruction and retroperitoneal fibrosis have been reported in association with a large number of entities but cause and effect are not established in some. Reported associations include:<sup>1,2</sup>

- (A) **Drugs:** Methysergide, Amphetamine, Methyldopa, L.S.D., Phenacetin, Colchicine, Hydralazine.
- (B) **Neoplasm:** Lymphoma, Sarcoma, Metastasis, Carcinoid.
- (C) **Trauma:** Hemorrhage, Urine Extravasation, Post-Surgical, Post-Radiation.
- (D) **Other:** Aneurysm, Crohn's disease, Histoplasmosis, Diverticulitis, Appendicitis.

Idiopathic retroperitoneal fibrosis has been reported in young children and the elderly but is most common in the fifth and sixth decades. The majority of young adults affected are women but the male to female ratio over age thirty is 3:1.

Signs and symptoms are usually insidious and less than one year in duration (average four months). Abdominal or back pain are the most frequent symptoms, followed by gastrointestinal symptoms, anorexia and fever. One patient in ten presents with anuria. Diverse non-urologic signs and symptoms reflect involvement of organs, vessels, and nerves by fibrosis.<sup>1</sup> Idiopathic retroperitoneal fibrosis has been associated with HLA-B27 antigen.<sup>5</sup>

The "classic" findings of retroperitoneal fibrosis on intravenous urography have been described as bilateral ureteral narrowing at the L4-5 level, medial deviation of the ureters, and dilation of the proximal ureters, pelves, and calices. In a review of 56 intravenous urograms, however, about 1/3 had unilateral disease and 7% had normal studies. It is theorized that patients with abnormal renal function and normal urograms or only minimal dilation have abnormal ureteral peristalsis.<sup>6</sup> Although medial deviation of the ureters has often been emphasized in the past, more recent studies have claimed that the ureters in retroperitoneal fibrosis are no different in position than normal ureters.<sup>7</sup> The sign of medial deviation of the ureters in retroperitoneal fibrosis should be de-emphasized since similar ureteral positioning is found with other diseases and in normal people. In addition many patients with fibrosis have no ureteral displacement.

Patients with poor renal function may require retrograde pyelography to demonstrate the collecting systems. A characteristic finding at retrograde pyelography is easy passage of the catheter past ureteral narrowing caused by retroperitoneal fibrosis. This finding again suggests that abnormal ureteral peristalsis is important in causing renal failure in retroperitoneal fibrosis.

Computed tomography clearly delineates the fibrotic plaque of retroperitoneal fibrosis. A mass of tissue enveloping the aorta and vena cava could be neoplastic as well as fibrotic. If the soft tissue mass is symmetric, smooth, and homogeneous, fibrosis is favored (Figures 3,4,5).<sup>3</sup> In some patients, however, retroperitoneal fibrosis has been irregular and indistinguishable from malignant disease of the retroperitoneum. Following contrast injection the opacified ureters are enveloped but not displaced by benign fibrosis.

Patients with retroperitoneal fibrosis caused by methysergide often improve when the drug is dis-

continued. The majority of reported cases of retroperitoneal fibrosis have been successfully treated by ureterolysis and lateral or intraperitoneal relocation of the ureters.<sup>1,2</sup> Treatment with steroids as an adjunct or alternative to surgery has also been successful in some patients.<sup>8</sup> ◀

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# Illinois Society, American Association of Medical Assistants

## Illinois Society, AAMA, Salutes The Certified Medical Assistants

BY MARYGRACE SANDERSON COOK COUNTY SOUTH CHAPTER

### CONGRATULATIONS LUELLA V. MITCHELL

Luella V. Mitchell, CMA, was elected Vice Speaker of the House of Delegates at the annual convention held in Kansas City, Missouri, October 13-17, 1980. Mitchell, a former author of articles published in the Illinois Medical Journal, has been employed as medical assistant and office manager for Ellsworth E. Hasbrouck, M.D. for 34 years. She brings a wealth of experience to the position of Vice Speaker because she has held both the Vice Speaker and Speaker of the House of Delegates positions in the Illinois Society, AAMA, for several years. Mitchell and the 19 Medical assistants listed below successfully passed the certification examination and were awarded their Certificates of Achievement as "Certified Medical Assistants."

LINDA BARUNICA, Granite City  
CONNIE BROWN, Belvidere  
ANDREA BURKE, Chicago  
SUSAN COX, Danville  
JEANETTE DU BOIS, Kankakee  
MARIE HOLT, Schaumburg  
SALLY HYDE, Danville  
LINDA HYMER, Naperville  
LYNN JOEGER, Chicago Heights  
CATHERINE KOERS, Danville  
CATHLEEN KUEKER, Prairie DuRocher  
DEBORAH LOY, St. Libory  
SALLY P. MASTERS, Danville  
ANDRIA MAZOL, Norridge  
NORMA ANN MEHRIENS, Waterloos, Ia  
HILAH JANE MOORE, Danville  
STANLEY POKRWIECKI, Chicago

CHERYL SMILEY, Westville  
HEIDI STADELMAIER, Lockport

The purpose of the AAMA certification program has been "to administer an accreditation examination and a revalidation program which identifies competent medical assistants who have met and continue to meet the professional standards established by the association."

The certification examination consists of questions concerning medical terminology, basic anatomy and physiology, psychology, human relations, patient contact, medical ethics, law and economics, administrative and clinical procedures. Specialty, Administrative and Clinical examinations are also offered.

Candidates for the Certification Examination are required to pass the entire examination in one attempt. The Certified Medical Assistant receives a Certificate stating the category of certification or revalidation and may wear a CMA pin which indicates the area of achievement. AAMA administers a certification program and has no registry or licensure authority.

Upon request AAMA supplies, without charge, an announcement brochure, an application form and a test center list. A *Candidates Guide to the AAMA Certification Examination* is available from the AAMA Executive Office at a nominal price. Group or individual study cassette tapes or programmed instruction tests constitute other means of preparing for the examination.

On the college level, AAMA and the American Medical Association are recognized by the U.S. Commissioner of Education and the Council on  
(Continued on page 415)

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BELVIDERE:** Seeking Board Eligible/Certified Family Practitioner to practice with two existing physicians in North Central Illinois. Town of 4000. Ultimately take over practice. 60 miles west of Chicago, 25 miles east of Rockford. Excellent opportunity for practice/family oriented physician. Contact: Harvey Pettry, 1625 S. State St., Belvidere 61108 (815) 547-5441. (5)

**CARBONDALE:** Primary care physician (M.D. or D.O.) for Health Service at prominent university which includes an aggressive wellness program and a school of medicine. Scenic recreational area combining the virtues of small town living with the cultural and shopping assets of a large metropolitan area. Attractive salary, 40 hour work week and generous fringe benefits. Ability to fluently converse in English and IL license required. A.A./E.O.E. For further information send vitae to Don Knapp, M.D., Medical Director, SIU-C Health Service, Carbondale, 62901. (3)

**CHICAGO: FAMILY PRACTICE DEPARTMENT CHAIRMAN**—Illinois Masonic Medical Center, 565-bed community general hospital near city center of Chicago needs chairman to head department of about 40 family practitioners with 3 full-time faculty and 10 residents; Active ambulatory care and educational programs. All major specialty departments represented within the medical center. Geographic full-time position with salary and allowance for private or group practice on terms to be negotiated. Communications to F. Archer, M.D., Chairman, Medical Staff Search Committee, Illinois Masonic Medical Center, 836 West Wellington, Chicago, 60657. (12)

**CHICAGO AREA SUBURBS:** Western Cook, DuPage Counties, including Oak Brook, Downers Grove, Wheaton, Lombard, LaGrange, Palos Hills. Opening in new and established multi-specialty medical groups. Complete office facilities with nearby hospital affiliations. Various practice and financial arrangement available. General Practice, Internal Medicine, Family Practice, Obstetrics & Gynecology, Otolaryngology, and Orthopedic Surgery. CONTACT: Jim Gott, Administrator, Suite 205, 6800 S. Main Street, Downers Grove, 60515, 312-852-9400. (12).

**CROSSVILLE:** Solo opportunity for a family practitioner. Small community in beautiful Southern Illinois aggressively seeking qualified applicant. Community will provide incen-

tives. Hospital 5 minutes from clinic. Call collect or write, Jack Rawlinson, Crossville Community Medical Center, 603 W. Main, Crossville, 62827. 618/966-2141 (3)

**DANVILLE:** Young emergency physician wanted for full-time position with career oriented, university affiliated, independent fee for service group. ACLS and board eligibility preferred. Send C.V. and 3 references to Dr. Laurence Webster, 3018 Golf Terrace, Danville, 61832 (217) 442-0735. (3)

**FAIRBURY:** Primary Care and Family Practice Physicians—excellent practice opportunities in a thriving rural community. Enjoy life and your new practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultured activities. Join the active medical staff of a growing 112 bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739 (815-692-2346). (12)

**FAIRFIELD:** OB-Gyn to join two physicians, one board certified family physician and one board certified surgeon, excellent professional and financial opportunity. Early partnership, no investment requirements, pension and profit sharing plans. Corporation will assume many financial obligations, such as malpractice insurance, health insurance, phone, gasoline. Call collect 618-842-2187, Fairfield Medical Center, Ltd., 101 East Center, Fairfield, 62837. (4)

**GENESEO:** Family Practice/Pediatrician/Internal Medicine/Orthopedic; acutely needed. Ultra modern hospital. Down town office, completely furnished. Population 7000, trade area 29,000. Prosperous farming area, 150 miles west of Chicago, Interstate 80. Contact: Mrs. A. W. Wellstein, 9 Maplewood, Geneseo, 61254 (309) 944-2530. (12)

**GLEN ELLYN:** Needed immediately—Qualified internist to join large multispecialty practice in Western Chicago Suburbs. Unique opportunity with recent clinic expansion. First year guaranteed salary with incentive and excellent fringe benefit package. Contact: Dave S. Bauer, Executive Director, Glen Ellyn Clinic, S. C., 454 Pennsylvania Ave., Glen Ellyn, 60137 (312) 469-9200. (3)



**HERRIN:** Trade Area 50,000. 16 Physicians at present. New Office, Established Practice; Near Medical School. Heart of Vacationland with many lakes and parks. 100 miles from St. Louis & Evansville. Total financial package. Contact Larry Feil, 201 S. 14th T., Herrin, 62948, 618-942-5594. (3)

**ILLINOIS DEPARTMENT OF CORRECTIONS** is searching for Medical Director (Chicago or Springfield) for statewide program and a Medical Director for Menard Correctional Center, Chester (20/40 hours/week). Submit C.V. to: M. Hall, Administrator, Health Services, Ill. Department of Corrections, 160 N. LaSalle, Chicago, 60601. (5)

**KEWANEE:** Population 14,500, trade area 50,000. Seeking to establish group of family practitioners to service towns within 15 mile radius. Located 60 miles from Peoria and Quad Cities. Financial and loan guarantees available. Practice would be centered at 112-bed full-service hospital. CONTACT: Harold Bischoff, 719 Elliott Street, Kewanee, 61443, 309-853-3361. (3)

**MT. CARMEL:** Population 9,500, located halfway between Evansville and Vincennes, Indiana on the Illinois border. Mt. Carmel is a community presently undergoing aggressive physician recruitment efforts and building a new hospital. Through the hospital, financial assistance is available and complete office facilities are provided. Contact Cliff Bauer, 1418 College Drive, Mt. Carmel, Illinois 62863, phone AC (618) 262-4121. (3)

**NORMAL:** Student Health Service needs physician to join primary care staff. Regular hours with no call and little paperwork. Good fringes and competitive salary. 11 month contract. Illinois license. CONTACT: William L. Warren, Student Health Service, Illinois State University, Normal, 61761, (309) 438-8655. Illinois State University is an equal opportunity, affirmative action employer. (12)

**OBLONG:** Unique economic opportunity for unopposed family practice in central Illinois community of 2,000 (County 20,000) with 50 bed nursing home, 9 miles from 70 bed JCAH hospital. Time-off coverage, office facilities, and financial assistance available. Minimum salary guarantee. Contact: Jerry Harmon, Oblong, 62449. (618) 592-4231. (12)

**PEORIA:** Excellent opportunity for an orthopedic surgeon, family practitioner, neurologist, OB-GYNE physicians in a multispecialty clinic of twelve physicians. Located in community of 250,000, three hospitals, medical school. Salary plus fringe benefits. Contact Dr. D. Holden, The Medical and Surgical Clinic, S.C., 100 Northeast Randolph, Peoria 61606. (309) 671-7400. (5)

**PONTIAC**—Are you . . . a Family Practitioner, Internist, Orthopedist, OB-GYN, or Pediatrician interested in practicing in a growing, north-central Illinois community of 12,000 (county 42,000), one and a half hours south of Chicago? Contact us in PONTIAC. Multi-specialty professional building adjacent to 118 bed JCAH Hospital. Hospital is trauma center, with ER coverage nightly, nuclear medicine, ultrasound, and more. Recruiting package includes income guarantee, office expense allowance, and relocation expenses.

es. CONTACT: Dean G. Peterson, M.D., or Steve L. Ursoevich, Administrator, St. James Hospital, 610 East Water, Pontiac, 61764. AC 815-842-2828. (5)

**SOUTHERN ILLINOIS:** Multispecialty group serving 20,000 population in Alexander and Pulaski Counties needs family practitioner. Complete office facilities and staff provided as well as guaranteed income and fringe benefits. Major university and colleges in area. Full range of outdoor recreational facilities year round. Contact: Steve Miller, Project Director, 529 Cross St., Cairo, 62914, 618/734-4200. (3)

**STERLING-ROCK FALLS:** Twin Cities on Rock River need Family Practitioners and ENT to complement 60-member Staff of 150-bed JCAH hospital-trauma center with CAP lab serving 90,000 friendly people. Superb recreation, good growth potential, guarantee. Call/write Darryl Wahler, Community General Hospital, Sterling 61081, 815-625-0400. (3)

**TAYLORVILLE:** Serving population of 30,000. Openings in OB/Gyn and family practice in 9-doctor multi-specialty clinic. Near medical school, universities, and state capitol. CONTACT: Thomas Brewer, M.D., 600 N. Main, Taylorville, 62568, AC 217-824-8191. (3)

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## AAMA

*(Continued from page 413)*

Post Secondary Accreditation as collaborative partners for the review of medical assisting programs offered by public and private health education institutions. Primary responsibility for this review function is carried by the Curriculum Review Board which is under the jurisdiction of the AAMA Endowment, a public education foundation. The AMA and the AAMA Endowment cooperate with the Committee on Allied Health Education and Accreditation, an autonomous agency which accredits the program. Belleville Area College in Belleville, Illinois, Robert Morris College in Carthage, Illinois, William Rainey Harper College in Palatine, Illinois, and Triton College in River Grove, Illinois offer Accredited Educational Programs for Medical Assistants. For information on how you can become a member of AAMA, please contact president Elaine Kaiser, CMA-A, 9103 Sandpiper Court, Orland Park, Illinois 60462 or Marygrace Sanderson, Chairman Public Relations Committee, 501 Heatherwood Road, Matteson, Illinois 60443. ◀

### References

1. AAMA Handbook
2. *Illini Cardinal*



# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603; (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

## JANUARY

### Family Medicine

#### 11th Annual Winter Refresher Course

For: FP's. Workshop/lecture, Jan. 28-30, Milwaukee, WI. Sponsor: Dept. of Family Practice, The Medical College of Wisconsin, Seton Tower, 2315 North Lake Drive, Milwaukee, WI 53211. Cosponsor: SE Chapter, Wisconsin Academy of Family Physicians. Fee: \$160. Reg. limit: none. Credit: Category 1, 19 hours; AAFP Prescribed, 19 hours. Contact: Susan Rechlitz. Phone: 414/291-0813.

### Hospital Accreditation

#### Program on Hospital Accreditation Standards

For: Medical Staff Leadership. Lecture, Jan. 22-23, Grand Rapids, MI. Sponsor: Michigan Hospital Assn., 2213 E. Grand River Ave., Lansing, MI 48912. Reg. limit: 200. Credit: Category 1, 11 hours. Contact: Mary Anne Butt. Phone: 517/484-7441.

### Psychiatry

#### Introduction to Individual Psychology II

For: MD's, Psychiatrists. Course, Jan-Mar, Chicago. Sponsor: Alfred Adler Institute, 159 N. Dearborn, Chicago 60601. Reg. deadline: 1/5. Fee: \$200. Reg. limit: 40. Credit: Category 1, 22 hours. Contact: Evelyn Wachman. Phone: 312/346-3458.

#### Interviewing Techniques

For: Psychiatrists, MD's. Course, Jan-Mar, Chicago. Sponsor: Alfred Adler Institute, 159 N. Dearborn, Chicago 60601. Reg. deadline: 1/5. Fee: \$200. Reg. limit: 40. Credit: Category 1, 22 hours. Contact: Evelyn Wachman. Phone: 312/346-3458.

### Psychiatry

#### Theory and Practice of Psychotherapy and Counseling I

For: Psychiatrists, MD's. Course, Jan-Mar, Chicago. Sponsor: Alfred Adler Institute, 159 N. Dearborn, Chicago 60601. Reg. deadline: 1/5. Fee: \$200. Reg. limit: 40. Credit: Category 1, 22 hours. Contact: Evelyn Wachman. Phone: 312/346-3458.

#### Psychological Tests & Measurements

For: Psychiatrists, MD's. Course, Jan-Mar, Chicago. Sponsor: Alfred Adler Institute, 159 N. Dearborn, Chicago 60601. Reg. deadline: 1/5. Fee: \$200. Reg. limit: 40. Credit: Category 1, 22 hours. Contact: Evelyn Wachman. Phone: 312/346-3458.

### Psychiatry

#### Group Therapy: An Experiential Course

For: Psychiatrists, MD's. Course, Jan-Mar, Chicago. Sponsor: Alfred Adler Institute, 159 N. Dearborn, Chicago 60601. Reg. deadline: 1/5. Fee: \$200. Reg. limit: 10. Credit: Category 1, 22 hours. Contact: Evelyn Wachman. Phone: 312/346-3458.

### Psychiatry

#### Marriage Counseling

For: Psychiatrists, MD's. Course, Jan-Mar, Chicago. Sponsor: Alfred Adler Institute, 159 N. Dearborn, Chicago 60601. Reg. deadline: 1/5. Fee: \$200. Reg. limit: 40. Credit: Category 1, 22 hours. Contact: Evelyn Wachman. Phone: 312/346-3458.

### Otolaryngology

#### Symposium on Otolaryngology

For: Otolaryngologists. Symposium, Jan. 21, 23, 28, and 30, 11:15 a.m., Oak Park. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Reg. limit: none. Credit: Category 1, 4 hours. Contact: Charles Weigel, MD. Phone: 312/388-7870.

### Radiology

#### Diagnostic Problems and Imaging

For: MD's. Course, Jan. 24-31, Humacao, Puerto Rico. Sponsor: Loyola University of Chicago, Stritch School of Medicine, Division of CME, 2160 S. First Ave., Maywood 60153. Cosponsor: Dept. of Radiology, Loyola University of Chicago. Fee: \$275. Reg. limit: 300. Credit: Category 1, 21 hours; AAFP Prescribed, 21 hours. Contact: Linda Gunzburger, PhD. Phone: 312/531-3236.

## FEBRUARY

### Anesthesiology

#### Regional Anesthesia

For: Anesthesiologists. Lecture, Feb. 16 (5 days), Chicago. Speaker: Alon Winnie, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$400. Reg. limit: 12. Credit: Category 1, 45 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

### Cardiac Rehabilitation

#### Comprehensive Cardiac Rehabilitation Workshops

For: MD's, RN's. Workshop, Feb. 9-13, La Crosse, WI. Sponsor: La Crosse Exercise Program, Workshop Unit, Mitchell Hall, University of WI, La Crosse, WI 54601. Fee: \$450. Reg. limit: 50. Credit: Category 1, 38 hours; AAFP Prescribed, 43 hours. Contact: Philip K. Wilson, MD. Phone: 608/785-8688.

### Cardiology

#### Symposium on Cardiology

For: MD's. Symposium, Feb. 4, 8, 11, 13, 18, 20, 25 and 27, 11:15 a.m., Oak Park. Sponsor: Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Reg. limit: none. Credit: Category 1, 8 hours. Contact: Charles Weigel, MD. Phone: 312/366-7870.

### Family Medicine

#### Lake County Medical/Surgical Seminar

For: MD's. Seminar, Feb. 18, Waukegan. Speakers: Naboth Mbawa, MD; James Monahan, MD. Sponsor: St. Theresa Hospital, 2615 Washington, Waukegan. Reg. deadline: 2/16. Contribution: \$3. Reg. limit: none. Credit: Category 1; AAFP Elective. Contact: R. M. Adelman, MD. Phone: 312/578-2551.

### Family Practice

#### Advances in Family Practice

For: GP's, FP's. Lecture, Feb. 9 (5 days), Chicago. Speaker: Harry Marchmont-Robinson, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$300. Reg. limit: 150. Credit: Category 1, 35 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

### Family Therapy

#### Strategies and Techniques (Intermediate Course)

For: Family Therapists, Psychiatrists, GP's. Workshop, Feb. 9-13, Chicago. Speaker: Robert Rutledge, ACSW. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Northwestern Memorial Hospital; Northwestern University Medical School. Fee: \$190. Reg. limit: 24. Credit: Category 2, 30 hours. Phone: 312/649-7285.

### Family Therapy

#### Family Systems Assessment (Introductory Course)

For: Family Therapists, Psychiatrists, GP's. Workshop, Feb. 2-6, Chicago. Speaker: Miriam Reitz, ACSW. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Fee: \$190. Reg. limit: 24. Credit: Category 2, 30 hours. Phone: 312/649-7285.

### Gastroenterology

#### 8th Annual Endoscopy Course

For: MD's. Lectures/workshops, Feb. 24-27, The Pfister Hotel, Milwaukee, WI. Sponsor: Section of Gastroenterology, The Medical College of Wisconsin, 8700 West Wisconsin Ave., Milwaukee, WI 53226. Reg. deadline: 2/10. Fee: \$300. Reg. limit: 250. Credit: Category 1, 23 hours; AAFP Elective, 23 hours. Contact: Walter Hogan, MD. Phone: 414/291-0813.

### Gastroenterology

#### Fifth Annual G.I. Assistants Course

For: G.I. Assistants. Lecture, Feb. 26, Milwaukee, WI. Sponsor: Section of Gastroenterology, The Medical College of Wisconsin, 8700 West Wisconsin Ave., Milwaukee, WI 53226. Fee: \$125. Reg. limit: none. Credit: CEU, 0.85 hrs. Contact: Marcia Pfeifer, RN, 1333 College Ave., Racine, WI 53403.

### Hematology

#### Basic Hematology

For: FP's, GP's, Internal Medicine, Pediatricians, Hematologists, Oncologists, Clinical Pathologists. Home Study Course. Sponsor: CME, University of Wisconsin, 481 WARF Bldg., 610 Walnut St., Madison, WI 53706. Fee: \$250. Credit: Category 2, 45 hours. Contact: Richard Hansen. Phone: 608/263-2853.

### Neurology

#### Basic Science of Neurology

For: Neurologists, Psychiatrists. Lecture, Feb. 23 (5 days), Chicago. Speaker: John Hughes, MD, PhD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$325. Reg. limit: 150. Credit: Category 1, 40 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.

### Psychiatry

#### Applied Adlerian Psychology

For: Psychiatrists, MD's. Seminar, Feb. 9-13, Ixtapa, Mexico. Sponsors: North American Society of Adlerian Psychology; Alfred Adler Institute of Chicago, 159 N. Dearborn, Chicago 60601. Fee: \$220. Credit: Category 1, 22 hours. Contact: Stuart Russell, Lee Kirkland Travel Services, Inc., 3537 Broadway, Kansas City, MO 64111.

### Quality Assurance

#### Quality Assurance for Psychiatric and Substance Abuse Facilities

For: Psychiatrists, Psychologists. Lecture/workshop, Feb. 12-13, Romulus, MI. Sponsor: Michigan Hospital Assn., 2213 E. Grand River Ave., Lansing, MI 48912. Reg. limit: 150. Credit: Category 1, 11 hours. Contact: Mary Anne Butt. Phone: 517/484-7441.

### Surgery

#### Society Review in Neurological Surgery

For: Neurosurgeons, Neurologists. Lecture, Feb. 6 (10 days), Chicago. Speaker: Leonard Krantzler, MD. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. Fee: \$600. Reg. limit: 250. Credit: Category 1, 101 hours. Contact: Robert Baker, MD. Phone: 312/733-2800.



# MARCH

## Family Medicine

**Clinical Management of Coronary Disease and Exercise Testing**  
For: Primary care physicians. Seminar, March 20-21, Hyatt Regency, Chicago. Sponsor: International Medical Education Corp., 84 Inverness Drive East, Denver, CO 80112. Reg. deadline: none. Fee: \$245. Reg. limit: 85. Credit: Category 1, 13 hours; AAFP Elective, 13 hours; AOA, 13 hours. Contact: Stephen Mattingly. Phone: 800-525-8848 x 238.

## Family Medicine

### Refresher Course for the Family Physician

For: FP's. Conference, Mar. 10-13, University of Iowa, Iowa City. Sponsor: College of Medicine, University of Iowa, CME, 285 Med Labs, Iowa City, IA 52242. Cosponsors: Dept. of Family Practice; Iowa Academy of Family Physicians. Fee: yes. Reg. limit: none. Credit: Category 1. Contact: Deborah Long. Phone: 319/353-5783.

## Family Therapy

### Sculpture: Working with Couples and Families

For: Therapists, Psychiatrists, GP's. Workshop, Mar. 8, Evanston. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Northwestern Memorial Hospital; Northwestern University Medical School. Fee: \$50. Reg. limit: 100. Credit: Category 2, 8 hours. Phone: 312/849-7285.

## Family Therapy

**Problem-Centered Systems Therapy—Intervention**  
For: Therapists, Psychiatrists, GP's. Workshop, March 23-27, Evanston. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago 60611. Cosponsors: Northwestern Memorial Hospital; Northwestern University Medical School. Fee: \$190. Reg. limit: 50. Credit: Category 2, 30 hours. Phone: 312/849-7285.

## General Medicine

### Respiratory Failure

For: MD's. Symposium, March 28, 1:00 p.m., Mt. Carmel. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Medicine

### Neurology Symposium

For: MD's. Symposium, March 28, 1:00 p.m., Pittsfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Medicine

### Dermatology

For: MD's. Symposium, March 25, 8:00 p.m., Maryville. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Medicine

### Respiratory Failure

For: MD's. Symposium, March 19, 1:00 p.m., Litchfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Medicine

### Traumatized Hand

For: MD's. Symposium, March 13, Springfield. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Medicine

### Gynecology Symposium

For: MD's. Symposium, March 12, 1:00 p.m., Jackson. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Medicine

### Hypertension

For: MD's. Symposium, March 11, 1:00 p.m., Brees. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Medicine

### Office Treatment of Anxiety/Depression

For: MD's. Symposium, March 5, 3:00 p.m., Quincy. Sponsor: SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. Fee: yes. Credit: Category 1, 4 hours. Contact: Lorraine Stephenson. Phone: 217/782-7711.

## General Practice

### The Positive Direct Coombs Test—What Does It Mean?

For: MD's, RN's, MT's. Lecture, March 19, 7:00 p.m., Davenport, IA. Sponsor: Mississippi Valley Regional Blood Center, 3425 E. Locust, Davenport, IA 52803. Speaker: David Jenkins, MD. Fee: \$15, MD; \$4, others. Reg. limit: 200. Credit: Category 1, 2 hours; AAFP Prescribed, 2 hours; Bd. of Nursing, 0.2 CEU; AOA, 2 hours. Contact: Patricia Harrod. Phone: 319/359-5401.

## Hospital Accreditation

### Program on Hospital Accreditation Standards

For: Medical staff leadership. Lecture, March 10-11, Indianapolis, IN. Sponsor: Indiana Hospital Assn., 3921 N. Meridian St., Indianapolis, IN 46208. Reg. limit: 200. Credit: Category 1, 11 hours. Contact: Jessica Manson. Phone: 317/928-1395.

## Internal Medicine

### "Gland Rounds" (What's New in Endocrinology)

For: MD's. Symposium/workshops, March 12-13, St. Louis, MO. Sponsor: CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. Fee: \$150. Reg. limit: 150. Credit: Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. Contact: Loretta Giacometto. Phone: 314/367-9873.

## Medicine

### Non-Articular Rheumatism

For: MD's. Lecture, March 16, 1:00 p.m., North Chicago. Speaker: Bruce Rothschild, MD. Sponsor: Div. of Rheumatology, UHS/CMS, Dept. of Medicine, VA Hospital, North Chicago 60064. Fee: none. Reg. limit: none. Credit: Category 1, 1 hour. Contact: Ben Blivaiss. Phone: 312/942-2985.

## Pathology

### Anemias: Morphology and Biochemistry

For: Pathologists, senior medical technologists. Workshop, March 30-April 3, Chicago. Sponsor: American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago 60612. Fee: yes. Reg. limit: 60. Credit: Category 1, 27.5 hours.

## Pathology

### 70th Annual Meeting

For: Pathologists. Symposium, March 2-6, Chicago. Sponsor: International Academy of Pathology, 1003 Chafee Ave., Augusta, GA 30904. Reg. deadline: none. Fee: varies. Reg. limit: none. Credit: Category 1, 45 hours. Contact: Nathan Kaufman, MD. Phone: 404/724-2973.

## Pediatrics

### Pediatric Infectious Disease Symposium

For: Pediatricians. Symposium, March 26-27, Marc Plaza Hotel, Milwaukee, WI. Sponsor: The Medical College of Wisconsin, 8701 Watertown Plank Rd., Milwaukee, WI 53226. Fee: yes. Contact: Willard Duff.

## Psychiatry

### Ericksonian Therapy

For: MD's. Lecture, March 25, 1:00 p.m., Forest Park. Speaker: Jeffery Zeig, PhD. Sponsor: Riveredge Foundation, 8311 West Roosevelt Road, Forest Park 60130. Fee: \$15. Reg. limit: 200. Credit: Category 1, 3 hours. Contact: Susan Cosgrove. Phone: 312/771-7000.

## Radiology

### Abdominal Imaging and New Techniques

For: MD's. Seminar, March 8-15, Vail, CO. Sponsor: CME, Loyola University of Chicago, Stritch School of Medicine, 2160 S. First Ave., Maywood 60153. Cosponsor: Dept. of Radiology. Fee: \$275. Credit: Category 1, 19 hours; AAFP Prescribed, 19 hours. Contact: Linda Gunzburger. Phone: 312/531-3236.

## Radiology

### Symposium on Radiology

For: MD's. Symposium, March 6, 13, 20, and 27, Oak Park. Sponsor: CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. Fee: none. Reg. limit: none. Credit: Category 1, 4 hours. Contact: Charles Weigel, MD. Phone: 312/366-7870.

## AMA 1981 CME Catalog

The AMA has published a new CME catalog listing of its 1981 offerings around the country. Included also is information about the AMA "Video Clinics" for home study and other AMA meetings on special subjects (e.g., rural health).

For your free copy of this catalog write or call:

Mr. G. K. Jewett  
Division of Continuing Medical Studies  
American Medical Association  
535 North Dearborn  
Chicago, IL 60610

## The Medical Library and CME

Every physician reads voraciously; good CME programs take advantage of this habit by supplementing formal sessions with good information sources.

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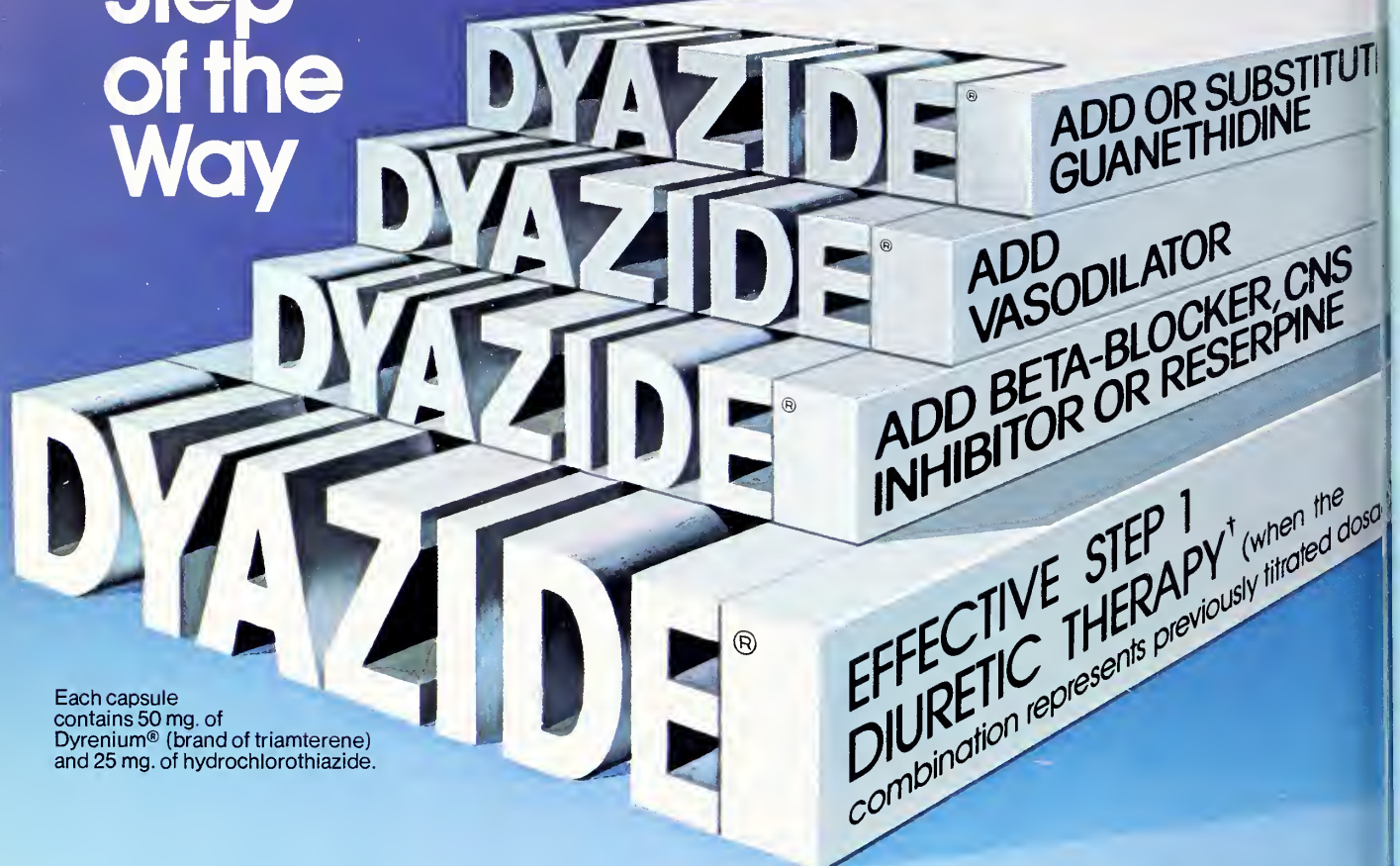
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**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K<sup>+</sup> levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K<sup>+</sup> intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, throm-

bocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K<sup>+</sup> frequently; both can cause K<sup>+</sup> retention and elevated serum K<sup>+</sup>. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Anti-hypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transiently elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with

possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

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# Doctor's News

**MEDICAL LICENSE RENEWAL**—In response to many inquiries, physicians who have not yet received notice that their license has been renewed are urged to write to Mr. John Dreiske, Illinois Dept. of Registration and Education, 320 W. Washington St., Springfield IL 62786 (217-785-0921). If your check has been cashed, it helps to note this, but do *not* send the cancelled check. If you have not been notified of renewal, inquire as to whether your name appears on the state computer as "not renewed." For those audited for CME who have not yet been notified, contact Mr. Dreiske as above. If you checked "no" to CME with your license renewal and were not audited, and have not been notified, even though your check was cashed, you may be listed by the state as "not renewed." Please write to R&E to ascertain your status.

It is apparent that many physicians remain in a quandry as to their license status. Inquiries addressed to Mr. Dreiske will identify the magnitude of the problem. Your letters are encouraged.

**REFERENCE ISSUE CORRECTION**—Page 260 of the October, 1980, *IMJ* Reference Issue incorrectly listed members of the Illinois Health Facilities Authority. The correct IHFA membership is as follows: John P. Dailey, Peoria, Chairman; Louis G. Alexander, Chicago, Vice-Chairman; William C. Fox, Champaign; Charles E. Hayes, Arlington Heights; Robert D. Kane, M.D., Herrin; Irene Mills, Decatur; Joseph S. Wright, Jr., Chicago; George Phillips, Chicago, Executive Director; and Francis C. Taylor, Chicago, Associate Executive Director. We apologize for this error.

**CIMA NAMES NEW EXECUTIVE VICE PRESIDENT**—The Central Illinois Medical Association (CIMA) voted during their meeting at the ISMS Interim Session to acknowledge retirement of David W. Meister, Jr., as executive vice president and name him executive vice president emeritus. M. John Hanni, Jr., CAE, was named to fill the post of CIMA executive vice president, in addition to his concurrent duties as executive director of the Peoria Medical Society.

**CANCER EDUCATION BULLETIN BOARD**—The Cancer Information Service of the Illinois Cancer Council provides a newsletter listing educational meetings on cancer-related topics. Persons wishing to receive the Cancer Calendar should write Kenneth Luurs, Coordinator, Cancer Information Service, 36 S. Wabash, Suite 700, Chicago IL 60603.

ICC announces that while the Dial Access tape system (provided by the M. D. Anderson Medical Center in Texas) has been discontinued due to a lack of funds, they are investigating establishing a local dial access tape system. They have already initiated a program providing Illinois health professionals consultation with dental and oncology nurse specialists on cancer-related concerns. (This is in complement to the ongoing Physician Consultation Program). Interested persons may call 800-972-0586 (In Chicago, dial CANCER-1) for telephone consultation.

**AID TO THE HANDICAPPED**—A special article in the December, 1979 *IMJ* (p. 469) outlined responsibilities to provide access to handicapped people under the Rehabilitation Act of 1973. In a recent release, the US Architectural and Transportation Barriers Compliance Board presented information on enforcement of that Act, and also noted available materials which may be of interest to handicapped patients. These include "Access Travel: Airports," a listing of accessible air terminals compiled in cooperation with the Airport Operations Council International and FAA. A parking "ticket" is available as well, which features a cartoon reminder for persons inappropriately occupying designated handicapped parking spaces. Forms and procedures for complaining about inaccessible buildings or facilities are included in the package, which may be obtained without charge from the Public Information Office, Architectural and Transportation Barriers Compliance Board, Washington, D.C. 20201.

**PHYSICIANS IN THE NEWS**—**John R. Tobin, Jr., M.D., M.S.**, Oak Brook, has been granted the 1980 Stritch Medal. An annual award of the Loyola University Stritch School of Medicine, the medal recognizes outstanding contributions to the medical profession. Dr. Tobin, a co-editor of the *IMJ* "EKG of the Month" series, is chairman of Stritch's department of medicine.

Sixteen Illinois physicians have been chosen to serve on AMA Board of Trustees Councils and Committees. These are as follows: *Ambulatory Health Care Committee*—**Herbert E. Natof**, Highland Park; *Committee on Accreditation of CME*—**Boyd McCracken**, Greenville, **Morgan Meyer**, Lombard and **George F. Stevenson**, Chicago; *Committee on Allied Health Education & Accreditation*—**Jack L. Gibbs**, Canton, **Alan Wolcott**, Chicago and **William Stewart**, Springfield; *Advisory Committee on Graduate Medical Education*—**Allwyn H. Gatlin**, Chicago; *Council on Medical Education Task Forces*—**Jack L. Gibbs**, Canton, **Richard Allyn**, Springfield, **David Aizuss**, Chicago (resident), **Fred Z. White**, Chillicothe and **Ann Nunnally**, Chicago; *Advisory Committee to CME*—**William M. Lees**, Lincolnwood; *Residency Review Committee (OBGYN)*—**Robert P. Johnson**, Springfield; *AMPAC*—**George T. Wilkins**, Edwardsville.

Newly named fellows of the American College of Cardiology are **Andrew H. Cubria, M.D.**, Chicago; **Serafin Y. Deleon, M.D.**, Chicago; **Jaime L. Fridman, M.D.**, Arlington Heights; **Witoon Weraarchakul, M.D.**, Bloomington and **Roland W. Winterfield, Jr., M.D.**, Evergreen Park.

The Illinois Chapter, American Academy of Pediatrics, has announced that their newly elected officers are: **Robert D. Hart, M.D.**, Peoria, president; **Agnes D. Lattimer, M.D.**, Chicago, vice president; **James H. Cravens, M.D.**, Quincy, secretary and **James W. Nicklas, M.D.**, Chicago, treasurer.

The American College of Chest Physicians has selected 14 research papers for special recognition at their upcoming annual scientific assembly. Two of the 14 researchers are Illinois physicians—**Patrick J. Fahey, M.D.** and **Ergun Onal, M.D.**, both of Chicago.

**REVISED STANDARDS AVAILABLE**—The Joint Commission on Accreditation of Hospitals has announced that the 1981 edition of the *Accreditation Manual for Hospitals* and also the *Hospital Survey Profile*, are now available. Accredited hospitals receive a complimentary copy of each manual. Additional copies may be obtained at a cost of \$20 for the former and \$12.50 for the latter by writing: Publication Sales Department, Joint Commission on Accreditation of Hospitals, 875 N. Michigan Avenue, Chicago IL 60611. Quantity discounts are available for orders exceeding 15 copies.

**HANDICAPPED PHYSICIANS**—*IMJ* recently received a request from Dr. Frank C. Zondlo of St. Paul, MN. Dr. Zondlo asks that we assist his efforts to contact other handicapped physicians in order to obtain some approximation of the size and characteristics of this population in the US and Canada. He noted that there is currently no organization to provide statistical data on the career patterns of such individuals or to what extent various handicaps affect the physician's ability to remain in active practice. Should any physician become handicapped, such information would be of value to his effort in determining the feasibility of remaining in any chosen field, and also provide indication of career opportunities available to this unique population. After determining the size and characteristics of this group, Dr. Zondlo plans to seek AMA involvement in forming a voluntary group of handicapped physicians who will provide information and referral services as well as support and advocacy for physicians who become handicapped. Interested handicapped doctors are advised to write: F. Zondlo, M.D., St. Paul-Ramsey Medical Education and Research Foundation, 640 Jackson St., St. Paul, MN 55101.











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